Standards Implementation Workgroup Public Hearing
Draft Transcript
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Presentation

Judy Sparrow – Office of the National Coordinator – Executive Director
Good afternoon, everybody and welcome to the Standards Committee Implementation Workgroup. This is a Federal Advisory Committee, which means there will be opportunity at the end of the meeting today and also tomorrow for the public to make comment. In addition, there will be a transcript available of both sessions today and tomorrow on the ONC Website. Just a reminder for people to please identify yourselves when you're speaking for attribution sake.

With that, I'll go around the table here and have the members introduce themselves, beginning on my left with Rob Anthony.

Robert Anthony – Centers for Medicare & Medicaid – Health Ins. Specialist
Rob Anthony, CMS.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
I'm Walter Suarez with Kaiser Permanente. I'm a member of the HIT Standards Committee.

Joe Heyman – Ingenix – Chair, National Physician Advisory Board
I'm Joe Heyman. I'm a solo GYN from Massachusetts and I'm also Chairman of the National Physician Advisory Board for Ingenix.

John Derr – Golden Living LLC – Chief Technology Strategic Officer
I'm John Derr from Golden Living. I'm also on the Standards Committee.

Anne Castro – BlueCross BlueShield South Carolina – Chief Design Architect
Hi, Anne Castro, BlueCross BlueShield of South Carolina and I'm also on the Standards Committee.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Larry Wolf from Kindred Healthcare representing Rick Chapman on the Policy Committee.

Marc Probst – Intermountain Healthcare – CIO
I'm Marc Probst with Intermountain Healthcare and I'm on the Policy Committee.

Paul Egerman – Software Entrepreneur
Paul Egerman, Software Entrepreneur and I'm on the Policy Committee.

Judy Murphy – Aurora Healthcare – Vice President of Applications
Judy Murphy from Aurora Healthcare. I'm on the Standards Committee and I'm Co-Chair of the Implementation Workgroup that's holding this hearing.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
I'm Liz Johnson. I'm from Tenet Healthcare. I'm on the Standards Committee and the other Co-Chair of the Implementation Workgroup.

David Kates – Prematics, Inc. – Vice President Product Management
I'm David Kates with Prematics and I am on the Standards Committee Implementation Workgroup.

Lisa McDermott – Cerner Corp. – Sr. Architect
Good afternoon, Lisa McDermott and I'm on the Implementation Workgroup and I'm from Cerner Corporation.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you and let me ask if there are any members on the telephone?

Rick Chapman – Kindred Healthcare – Chief Administrative Officer/CIO/EVP
Hi, this is Rick Chapman from the Policy Committee. I'm on the phone, Judy.

Judy Sparrow – Office of the National Coordinator – Executive Director
Anybody else? Okay, with that I'll turn it over to Judy Murphy and Liz Johnson.

Judy Murphy – Aurora Healthcare – Vice President of Applications
By way of introduction for the hearing, we thought we'd give a little bit of background information, just to set the tone for the hearing this afternoon. A big thank you to the Implementation Workgroup members, we had monthly conference calls to set up the questions and to vet the members who are going to be asking the questions today and also to come up with the panelists that you'll be seeing this afternoon and tomorrow. So, again thank you to the Implementation Workgroup members.

The broad charge of the Implementation Workgroup of the Standards Committee was to really bring forward real world implementation experience into the HIT Standards Committee recommendations with specific emphasis on strategies to accelerate the adoption of proposed standards or mitigate barriers, if any. So, as we thought about that we evolved some objectives to provide feedback and/or a reality test for both the Policy Committee's and the Standards Committee's recommendations. In other words, do they make sense from an implementation standpoint? Where are the synergies and where are there concerns?

A second objective was to encourage and advertise the use of existing resources, such as some of the things like the Health IT Buzz Blog, the Federal Advisory Committee Blog, the Health IT Journey: Stories From the Road, as well as the frequently asked questions posted by ONC and CMS. Many of our testifiers actually threaded their use of these tools into their testimony, so we'll be hearing more about that.

We are going to have five panels and two of the panels will be held today and three of the panels will be held tomorrow. The first is on implementation support through the use of the regional extension centers. On that panel, we'll have testifiers from both regional extension center providers as well as regional extension center users. That's going to be our first panel that's seated here. The second panel on implementation support is going to give us some information on the certification journey. On this one as well we have a certifying organization. We also have vendors that have been certified and testifying regarding their experience.

The third panel, which will start out the morning tomorrow, will be on Implementation support related to the use of Health Information Exchange and the state designated entities. Then we'll have Panel 4A and 4B, so there's two different panels on early adopters seeking attestation from the provider space. Then the fifth panel, there will also be an A and a B, so we'll have two sets of panels on early adopters seeking attestation for eligible hospitals.

With that, I will turn it over to Liz. Any comments?

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
I think one of the things that we'll be able to share with you via posting is there was a significant amount of work done by our testifiers where they wrote out testimony and showed us documents that helped

them through their implementation processes, through their certification processes and so on. I would absolutely advise you to go out there and take advantage of those documents. They are very thoughtful and thorough. I found them to have a significant amount of information that certainly can't be shared in a five-minute testimony. Also, as you listen to our testifiers please formulate your questions as we go around this table so that we're prepared to take advantage of the expertise that sits in front of us.

There are two other persons that I'd like to ask—Paul and Mark—to speak for just a moment. These two gentlemen from the Policy Committee joined us—they are a consorting together—they joined us and were very instrumental in the way we formulated our hearings, our testifying group and so on, our questions. So, Paul and Mark, would you like to add some comments, please?

Marc Probst – Intermountain Healthcare – CIO
We really appreciate the opportunity to be here. Back in October, we had looked at, boy, we really need to get some information as we start down the journey to stage two meaningful use. Under Paul's leadership, primarily we were involved in the Certification and Adoption Workgroup and putting together a lot of the certification requirements that ONC ultimately worked with, but we felt that there was a lot we needed to learn. As we started down that journey one, time went past us really, really quickly.

Secondly, we saw that the Implementation Workgroup was going to do some things very similar, or at least gather information similar to what we needed. So, it was very kind of Liz and Judy and Judy to pull us in and allow us to have some influence over the hearings that we'll have over the next day and a half and be here to learn so that we can take things back to the Policy Committee.

Paul Egerman – Software Entrepreneur
I just want to say, I'm looking at the panel that's here, I read your material and I very much appreciate your efforts and looking forward to hearing your testimony.

Judy Murphy – Aurora Healthcare – Vice President of Applications
With that, I will turn it over to the moderator of our first panel, Anne Castro.

Carol Diamond – Markle Foundation – Managing Director Healthcare Program
Liz and Judy, I just want to let you know I'm on the line.

Anne Castro – BlueCross BlueShield South Carolina – Chief Design Architect
Hello. Thank you for coming today on such a treacherous travel day for the south. I'm missing a free snow day. Today, our first group is the Implementation Support – Regional Extension Centers. Like Judy said, we have a combination of REC: participants from the ones who created the RECs and the ones who are using the RECs. So I think your testimony is going to be great for us today to learn how that experience is going.

We have a set of questions that we have set out, just for those of you who might not have had them nor had time to look at them. We're asking about the challenges and barriers and successes when providing services for RECs or using the implementation support, the REC user, so it kind of goes both ways with the combination testifiers. We're going to outline the implementation support and methodologies that were used that worked and didn't work, including any real world user stories, illustrations or examples. Discuss outcomes and results, include any surprises or unexpected outcomes and how you address them. Describe your experiences using the ONC and CMS communications regarding the meaningful use criteria, standards, specifications and measurements.

That's the guidance we gave the testifiers and they all have provided excellent information. I just want to point out that we have a five minute limit with a hard stop. I was advised today to let you know if you go over the five, we're putting you on the no fly list, so a little bit of your own tingle in the back of your head when that ticker starts ticking down. We do need to have some time to ask some questions and I think we've all studied the information that you've provided, so that's been very helpful. I'll remind the

members of the committee to raise your cards when the testimony is over so that we can go in the order that we have become accustomed for questions and answers.

I would like to introduce our panelists. First, we have Clayton Gillett, Executive Director—and I'm just going to go ahead and say the letters because I'm sure there's a kitschy little way of saying them that I will mess up—so it's O-HITEC, Oregon's Regional Extension Center. Then we have Lisa Levine, MHP, Vice President Operations of Family Health Center of Worcester, Massachusetts; Dan Nelson is number three, Desert Ridge Family Practice, Phoenix, Arizona; Paul Kleeberg, M.D., Clinical Director, Minnesota/North Dakota Regional Extension Assistance Centers and then Mat Kendall of the Office of the National Coordinator with Allen Traylor with him. We can start with Clayton Gillett, if you don't mind.

Clayton Gillett – O-HITEC, Oregon's Regional Extension Center – Executive Director

I appreciate the opportunity to speak to the committee and being from Oregon I have to start my testimony with "Go Ducks," but to be more serious, I'm grateful for the opportunity for just a few minutes to talk about our successes, the barriers and how things are going in Oregon. I want to flip a little bit and just talk a little bit about the successes to begin. OCHIN is the health center controlled network that supports 40 FQHCs and rural health centers around the United States, 15 of which are in Oregon. One of the huge successes for us is that by February we'll be ready for all those organizations to attest to meaningful use. So, we feel like we're a huge success in that way and we're excited to be able to talk about that.

Oregon is different than most of the states. We have 65% of our providers already on systems and so we have lots of IPAs in the state that also support groups of providers on hosted solutions and they are very near meaningful use. So we expect several of those groups as hosted solutions to come and attest very early in the year. This represents a huge success for those groups as well.

Another success of the policies that you've put together is many providers in our state have chosen systems and made choices on the inexpensive side of the market possibly and are taking this opportunity to switch out systems that more effectively meet the requirements. That's a huge opportunity for these organizations because they wouldn't have the financial capital to do that without meaningful use and those dollars coming from the federal government.

Oregon is building some really tight relationships with the Health Information Exchange as well as the state organizations and the IPAs to work to create an environment, a culture of quality improvement across the state. The policy has resulted in the organizing mechanism for that to happen and that's a huge success of this policy.

When we talk about barriers to this policy and the rules that go along with it, the providers who had implemented it in the past have invested heavily in the systems that they already have and they're very unlikely to change. Several of those systems may not be kept up to date. There are barriers around, especially the single provider groups who have not kept up to date with the latest versions and they have huge barriers to overcome to get those implementations up-to-date to meet meaningful use on the most recent versions.

Not all providers are convinced that they need any help other than the vendors to get to meaningful use. That's a barrier for us in helping them understand what it really means to get there. The complexity of the system, the complexity of meaningful use and the rules and how they apply to rural health centers versus critical access hospitals versus FQHCs versus which providers are eligible providers in each area is a constant source of confusion for the providers in our community.

Finally, even though we have 65% of our providers on systems, the market is maturing. As the market is maturing, it's changing what the requirements are. So, as the market moves to an area— There is no killer application out there in my view. There is no iPad; there is no Walkman that changes the way we do something in a fundamental way. It doesn't change the way we document. These systems help us

document more efficiently, but there is nothing out there that really changes the game. As a result, things are moving fairly quickly towards a much more centralized approach, so you see much more cloud computing, much more how can we squeeze the dollars out of the system. That's happening quickly, but for those who have implemented systems, that's a barrier because all that investment that they invested in some physical location somewhere all of a sudden becomes an anchor, it becomes a cost center. You have to grow to be a huge size to compete with the vendors of today who are implementing cloud source solutions, software as a service kind of models. So, we worry about the people who have already implemented and what's going to happen to them.

Now, I will say that the expectations for critical access hospital in our rural hospitals are much higher than the ambulatory requirements. That is a huge barrier. They have few vendors that can help them get there well and they have fewer resources to help them, so I want to call them out separately.

I also want to say real quickly in conclusion that I think in order for us to be really successful we have to have really good systems of centralized data that allows comparison of data across providers. Right now those tools aren't available and they're not available out-of-the-box even out of certified systems, so I encourage us to move forward aggressively around these areas to make sure certification standards improve.

Anne Castro – BlueCross BlueShield South Carolina – Chief Design Architect
Thank you, Clayton. That wasn't as hard as it was supposed to; I was busy writing a question down that I'm going to ask you later. Sorry, Lisa, I'm paying attention now.

Lisa Levine – Family Health Center of Worcester Massachusetts – Vice President, Operations
Well, I, too, would like to thank the committee for the opportunity to share the experience of the Family Health Center of Worcester. We're a federally qualified health center serving over 33,000 patients a year. Over a year ago, we started our implementation of NextGen, our electronic health record system and hopefully, hopefully, we'll be fully paperless by March 1st.

There's much to commend in the HITECH Act. It's hard to argue with policy goals that focus on improving quality, safety, efficiency and care coordination, but like most major change, translating policy to practice is the really difficult work. Before the HITECH Act, Massachusetts, always trying to be ahead, passed Chapter 305 in 2008, which mandates, among other things, that all physicians as a condition to practice medicine be certified by 2015 in the use of an EHR. Anticipating the changes ahead, the Massachusetts League of Community Health Centers, which is our HRSA funded primary care association, provided technical and infrastructure support to help its members in the adoption of electronic health records, which I have to say, is one of the most daunting challenges facing our health center and I'd suggest other health centers across the country.

The Regional Extension Center in Massachusetts made a concerted effort to reach out to community health centers and for very good reasons. Centers in Massachusetts have made significant headway in planning for and obtaining and implementing electronic health records. They're more inclined to appreciate the role of the REC.

Health centers also would help the REC move toward its goal for enrollment because of the large number of eligible providers that we employ. Unfortunately, unlike other state RECs, our model does not fully accommodate the uniqueness of community health centers. Rather it's built for a system of individual and small private practice providers. Our REC charges a $600 enrollment fee for primary care providers and $800 for specialists. For my health center, it costs us $21,600 to enroll our 36 providers. That may not seem like a lot of money to some, but for our health center, it's a significant amount of money. It was an unanticipated and unbudgeted expense, which, frankly, we felt we had no choice but to spend because we really need the help.

There is just too much to know, too much to do and too little time to do it in. The REC provides a very important service in vetting the IOOs and application vendors that seem to proliferate. The Mass League of Community Health Centers is our IOO of choice and while I have great confidence in the League's work, it's also good to know that someone outside our association will be monitoring its work as an IOO. Adopting meaningful use requires a major transformation in the systems delivery and practices at our health center. Providers must accommodate to an entirely new approach to the patient visit, which takes time and takes a toll on productivity and, therefore, revenue.

During the first week of EMR implementation, our provider productivity decreased by 75% and we have not fully rebounded. The loss in patient access and in revenue during this period is significant and extremely difficult to make up. This loss of revenue comes at the same time that family health must find the money to build and sustain an infrastructure to support health information technology and meaningful use. It is true that the REC and its contracted IOO will provide us with technical assistance and advice, but the IOO is not at Family Health Center every day. It does not download the system upgrades from NextGen. It does not work through a template during a patient visit with a frazzled, frustrated and angry doctor. It does not manage an interface or interoperability with a hospital system and it certainly does not fix broken printers, train new staff and maintain mandated policies and reports.

I am not sure how much more will be gained besides a work program from consultants by creating the intermediary structure of an IOO. Frankly, we would have been better off if the funds passing from the REC to the IOO went directly to us so that we could build a sustainable infrastructure. We then could have worked directly with the REC in an expanded role. With or without an IOO, we still have to compete to build this infrastructure for health technology staff at a time when there is a national shortage of this particular work force and we are at a recruiting disadvantage.

I suggest that the ONC consider utilizing the REC in the design and implementation of work force initiatives. There is so much information coming at us on a daily basis that it is really hard to keep track of the regulations, deadlines, and policies. We don't have the staff to dedicate to tracking the growing body of information coming out at the federal and state levels. Without the updates from the REC and the Mass League, we would be at risk of missing critical steps.

Anne Castro – BlueCross BlueShield South Carolina – Chief Design Architect
Lisa, your time is up. Thank you for the information that you fit in in that small five minutes. Dan?

Dan Nelson – Desert Ridge Family Physicians – Practice Administrator
First off, I would like to thank the ONC and the Implementation Workgroup for having me here to share my experiences and opinions. My name is Dan Nelson and I'm the Practice Administrator for Desert Ridge Family Physicians located in Phoenix, Arizona. Prior to joining Desert Ridge Family Physicians, I had worked as a mechanical engineer and have held positions as both a process engineer and as a project manager. Despite the fact that my background is from unrelated industries, I've been able to apply many of the lessons learned there to this small medical practice environment.

Desert Ridge Family Physicians has six physicians and a support staff of 11. We opened our doors six years ago with a very progressive model of family medical care, which includes open access scheduling, a commitment to evidence-based medicine, a patient-centered philosophy and the use of NextGen Healthcare's electronic health record system. As a small practice, we know all too well the difficulties that similar practices face when attempting to implement an EHR and to meet the requirements of meaningful use. There are too few people, too few resources, and too little time to tackle it all alone. All practices want to improve, want to modernize and want to gain in efficiency, but they want the process to be easier. Yet, modernizing our healthcare system is too important a goal to continue to wait, which is why I'm so supportive of the Regional Extension Centers.

In Arizona, our REC is staffed by experts with a wealth of knowledge and experience with EHRs, quality improvement and project management. Small practices like ours do not need to tackle such an

enormous project alone. With the experts in our REC, providers can get assistance with any aspect of meaningful use, whether it's a readiness assessment, selecting and implementing an EHR, improving work flow, measuring quality or any other type of guidance. Furthermore, our REC has built up a network of providers and resources, which further extend their capabilities and allows them to match the problems of one practice with solutions from another.

The implementation of a new EHR is a very daunting process. There are so many hurdles that must be overcome. The assistance from the REC will save practices an immense amount of time. Perhaps more importantly the experience of the REC can prevent practices from making those missteps that can either slow down or halt progress and can even derail the entire project. That collaboration has been the biggest success that we've seen from our REC. For a much more detailed description of the Arizona Regional Extension Center and its successes, please refer to my written testimony.

One of the key barriers we've seen in Arizona is the confusion that exists within the medical community on the future direction of the healthcare industry. On the political side, there continues to be an uproar over healthcare reform and the inability to find a permanent fix to the Medicare suggested growth rate payment schedule. All of this confusion and noise is leading many practices to adopt a wait and see approach towards any changes to their medical practices.

Another barrier that I've seen is the focus on stage one of meaningful use by both EHR vendors and Regional Extension Centers. In my opinion, the technical bar of stage one is really quite low. I believe that there are currently over 150 EHRs that have been certified, but I wonder how many of them will be able to meet the goals of stages two and three.

My concern is that there are too many underqualified EHRs that are getting certified, which adds a false legitimacy to their products. For practices that are evaluating EHRs they may see a low price tag, a simplistic system, a certification star and perhaps a money back guarantee, which may be all the justification needed to make their choice. But down the road, if the vendor is unable to meet stage two or three, a money back guarantee will be useless to reclaim the lost time and effort for implementation. Unfortunately, some practices will certainly be caught in this situation.

What's worse, however, will be if these underqualified systems are widely deployed and they represent a significant market presence. If that's the case, the technical requirements of stages two and three will need to be lowered if they are to remain attainable. In my view, watered down requirements will undermine the goals of the entire program.

I believe the Regional Extension Centers have a duty to protect against this possibility by steering practices towards qualified EHRs. The RECs should represent the best interests of the communities they serve by ensuring that providers are using capable systems. When enough of these systems are in place the medical community will benefit greatly. Communications between providers will be simplified and streamlined, thereby allowing for better care coordination. Streamlined access to medical records will improve follow-up care and eliminate duplicate tests, preventive care will improve, outreach will become proactive instead of reactive. All of this can become a reality, but it will depend on the success of the RECs to guide the way.

Thank you, again, for allowing me to be here and for giving me the opportunity to share my opinions.

Anne Castro – BlueCross BlueShield South Carolina – Chief Design Architect
Thank you, Dan. I'm going to recover that 17 seconds for my mess up on the front end. Okay, Paul Kleeberg.

Paul Kleeberg – Minnesota/North Dakota REACH – Clinical Director

Good afternoon and thank you for the opportunity to participate in this panel. My name is Dr. Paul Kleeberg and I'm the Clinical Director of the Regional Extension Assistance Center for HIT serving the states of Minnesota and North Dakota.

In my written testimony, you will see details about our Extension Center, statistics about EHR use in Minnesota and North Dakota as well as the details behind the topics I mentioned in this statement. First, as background, Minnesota has seen a significant penetration of electronic health records and physician practices in both states and large health systems. Adoption in small and critical access hospitals is not nearly as extensive. Our first challenge as an Extension Center was the complexity of the program requirements combined with a short timeline. The short timeline appears to have been mitigated with possible extension of subsidies of two years. A number of barriers prevented customers from accessing our services; ignorance of the Incentive Program and of Extension Centers, paying the provider 10% match, access to capital to purchase an EHR, EHR vendors who promised to do it all for them, and finding time for individuals in small facilities with multiple responsibilities devoted to the process.

We worked to overcome these in a number of ways. We gave presentations about meaningful use of EHRs, the cultural change it requires and the services our Extension Center can provide. We collaborated with local medical societies and professional organizations. We met with EHR vendors and health systems which sublicensed their EHRs to affiliates so they understood how we could facilitate their installation process. We offered all-day boot camps on the Incentive Program, which utilized problem-solving and small group work to give attendees a deep understanding of meaningful use and the implications for their work flow. Our success in recruiting was bolstered in North Dakota because the state would cover a provider match in Minnesota due to its revolving loan program.

Moving on to our methodologies, once a clinic signs it is important to keep its staff focused on the true reason they're pursuing meaningful use. It's about their patients and about quality. Roughly half of the time we spend with a client is spent before the EHR contract is signed in order to create a solid foundation of the vision and goals. This gives them the strength to work through the tough stuff. We divide the methodology into small pieces and are firm about identifying a project manager and a physician who can devote significant time to the process. We serve as mentors to our clients. They do the work so when done, they have the skills to adapt for the next challenge.

We've had successes working collaboratively with our clients in groups, with our state's e-Health Advisory Committee to coordinate with the other grantees and with the ONC's Health Information Technology Resource Center where we share tools and resources with other extension centers. It didn't work for us to instill a sense of urgency in potential clients. In their mind, the deadline was far off in 2015. It also didn't work to let the client run the show. Often they wanted to jump to the selection process and then found it very difficult to make decisions, causing us to backtrack and pick up where we had wanted to start with vision and goals.

Now, our results: For clients who are already live on a certified EHR product meeting the meaningful use criteria will not be difficult. We expect most of these providers to begin demonstrating it sometime this winter. For clients who do not have an EHR, they've made very good progress with our methodology bringing many through to selection and signing with a vendor, but for those who are not live on a certified EHR, there is often a holdup of vendor implementation timelines. We've been surprised by what some of our clients can accomplish. Once critical access hospital using our meaningful use assessment has been working with its vendor to make its product better and help create training materials for the vendor's new release to be used nationwide. Communications from CMS and ONC regarding the criteria, standards specifications and measurements have been helpful, timely and clear. However, turnaround for documented answers to questions has been slow, likely due to the number of offices needed to approve them before they can be released.

There are two items I'd like to draw to your attention that were not specifically called out by the questions. First, critical access hospitals are having a particularly difficult time adopting and implementing electronic

health records. There are few vendors to choose form and their certified ambulatory modules are only now being developed. It's a shame that early adopters, typically large systems who already have certified EHRs in place will be able to achieve the funds while the neediest of hospitals will be left behind. Those issues are compounded by the shortage of support staff within the community to help implement and support the EHR and a shorter time window for critical access hospitals to achieve the full incentive.

Secondly, I'm concerned that the meaningful use certification standards are not nearly as robust as the CCHIT criteria used previously to certify electronic health records. I fear that some sub-standard EHRs will be … certified, but not have the features that providers have come to expect. I'm not proposing a solution today, but wanted to draw it to your attention.

I thank you for your time and consideration. I look forward to your questions.

Anne Castro – BlueCross BlueShield South Carolina – Chief Design Architect
Thank you, Paul. Mat, I think we're real happy to hear from ONC on this, so I'll be a little more lenient on your time.

Mat Kendall – ONC – Director, OPAS
Oh, appreciate that. I was trying to think of ways I could get… myself into conversation and reward you.

Anne Castro – BlueCross BlueShield South Carolina – Chief Design Architect
I think you can go ahead.

Mat Kendall – ONC – Director, OPAS
Thank the committee very much for the honor of speaking today and also for the other panelists. I think it's fabulous to hear from real people doing this stuff. My name is Mat Kendall and I am the Director of ONC's Office of Provider Adoption Support, which we refer to lovingly as OPAS. Our job really is to support the great work that's being done in the field to help ensure that all providers get the resources they need to successfully implement EHR systems and, more importantly, achieve meaningful use.

What I thought I would do today is provide an overview of some of the areas that we're working on. I also have the privilege of having Allen Traylor here who is also on my team. He focuses on one of our areas of meaningful use and I'm going to ask him to speak specifically about that.

In terms of my office, we have four programs that we're supporting. We have the Regional Extension Center Program. We have the Health Information Technology Research Center or HITRC that we support. We also support the Community College Workforce Program, which we talked about earlier. Then, finally, we have a great team that is focusing on meaningful use, both the policy supporting the early adopters, which we call our meaningful use vanguard or movers, and then also thinking about ways in which we can make sure we get best practices out into the field along with meaningful use.

So, just going through each one of the different programs our Regional Extension Center Program in the last year awarded 62 Regional Extension Center Awards across the country. We now have Regional Extension Centers that have service areas that cover the entire country. The goal of this program is to support 100,000 providers at least that focus in what we call our priority primary care settings achieve meaningful use in the next few years.

The focus of the Regional Extension Center, when we talk about those priority areas, we're really going after the small practice provider office with less than 10 providers;… qualified health centers, critical access hospitals, rural health centers, public hospitals or providers that are serving medically under-served groups. The focus is intentional because we are concerned that these groups of primary care providers are going to have very, very significant challenges in achieving meaningful use and I'm glad that there are people on this panel that can speak more directly to that than I. The way in which our program is designed is that each of our Regional Extension Centers has to get a certain amount of

providers based on the number of providers in their service area to meaningful use and we're monitoring them through three goals, three milestones, rather.

The first one is enrollment, getting providers that are willing to take on this big challenge and get live on the system. The second point is getting providers to be live on an EHR system and the third is actually to get them to meaningful use. We deployed a customer relationship management software tool, CRM, that we're using right now and I can tell you that we have over 35,000 providers signed up among the Regional Extension Centers. We have a growth of about 5,000 a month in terms of enrollment and we've changed recently some of the structures of the Regional Extension Centers to address some of the concerns that they had about timeline and cost share and we hope that this will increase the acceleration of sign up.

One of the things we're doing with our HITRC is we are really trying to create a community of practice where we can begin sharing best practices among the Regional Extension Centers. We're created an online Web portal where we're facilitating exchange of information among the Regional Extension Centers and developed 12 communities of practice where experts from the Regional Extension Centers can come together to share best practices. We set up a number of meetings last year. We had five regional meetings across the country with over 750 participants to talk about ways in which we could learn about the information that we're going out there, we had a meaningful use boot camp, but then also sharing best practices and doing in-depth training. We also supported the first ever ONC Annual Meeting and Training that we had in the fall with 1,100 participants. We're hoping to do more of that work as we go forward and begin to develop tools and trainings to address the gaps that are developed.

Our Community College Workforce Program: We have 84 community colleges across the country, under five grantees that are really working to train folks for the workforce capacity and we think this is very, very important. We've got 3,400 students that are currently enrolled in these programs and will begin matriculating in April. Again, most of these are Web programs working very closely with our Regional Extension Centers because our goal is that there are plenty of people who need these jobs, especially in the critical access areas that we may go forward to.

One of the things I should mention is that critical access hospitals are an acute area of concern for us. We share the concerns that we've heard from our Regional Extension Centers and we've now released two supplemental grants to provide additional funds to the Regional Extension Centers for work on that, but clearly there's a lot of work to be done.

I'm now going to turn it over to Allen to talk a little bit more about all of the work we're doing with Meaningful Use Team and I appreciate the extra little time.

Allen Traylor – ONC – Meaningful Use Policy Analyst

Thank you very much for having me. Of the programs that Mat talked about there are two that are really driven by the RECs, two that are driven by the RECs that pertain to meaningful use, in particular. The couple of programs are in place to gather real world feedback from the providers that go into the Regional Extension Centers and then come into the ONC to help the Regional Extension Centers and the ONC develop tools and resources and education modules to support the adoption and meaningful use of electronic health records to improve quality.

The first is a Meaningful Use Community Practice. It's completely led and driven by members from all Regional Extension Centers. The community meets biweekly to gather resources they found in the field. They're supported by five HITRC contractors to develop tools and find tools and resources to help providers achieve meaningful use. The Community Practice is there to really bring up sort of the rising of the tide, as one Regional Extension Center gains knowledge and best practice about a particular area of meaningful use they can share it with all of the other Regional Extension Centers.

The other program is what we call the Move Program; it's the meaningful use vanguard. We're fortunate enough to have the support of the Regional Extension Centers identifying movers, which are physicians in the field that really exemplify a good will to improve quality and efficiency through the use of electronic health records. The movers are testers; they'll help test tools, they'll help look at resources and help really bring the local community together to achieve meaningful use and adopt electronic health records.

Again, both of those program are really driven by the Regional Extension Centers and some of the folks that you see here on the panel today and that you will hear from tomorrow. In particular, I think you will hear directly from an identified mover. So, those are the two programs that I wanted to highlight. Thank you.

Anne Castro – BlueCross BlueShield South Carolina – Chief Design Architect
Thank you very much for your testimony and if the committee would like to raise their cards to ask questions, now is the time. Okay, order is going to be questionable, but I saw John to my right put his card up first.

John Derr – Golden Living LLC – Chief Technology Strategic Officer
This is a question for Paul. You mentioned a lot about EHRs and helping with EHRs. Do you find that many of these people don't have an EMR to begin with and are you helping them to first establish an EMR so they can then populate an EHR?

Paul Kleeberg – Minnesota/North Dakota REACH – Clinical Director
Well, I'd like to respond to that question by saying there's a great deal of controversy on how you define EMR and EHR. Some people define EMR as being a computer system that works in a doctor's office whereas EHR is something more global. So, I'd like to actually turn the question around and back to you and could you clarify that question to me, because I don't understand it.

John Derr – Golden Living LLC – Chief Technology Strategic Officer
I'd be very happy to because it's sort of one of my windmills. There is an HSS publication that defines EHR, EMR and PHR and an EMR is really basically a facility or provider within their facility. EHR is more for the transition of care between different facilities and a PHR you can imagine. But there is a pub out there that gives all the definitions and I find I represent long-term post-acute care and if we don't get those nomenclatures straight, a lot of the testimonies are talking about EMRs within hospitals and that when we really want to talk about an EHR for certification and not an EMR.

Paul Kleeberg – Minnesota/North Dakota REACH – Clinical Director
To respond to your question, I do believe a lot of doctors' offices have EMRs and I believe a lot of us, even though we think we have EHRs there are still islands of information. I believe the whole concept behind Health Information Exchange and getting patients involved in their care will move us more toward a true electronic health record where the patient begins to own the record system. That's part of our goal as an Extension Center is actually to make it so that the record becomes something that follows the patient and actually improves the quality of care.

Anne Castro – BlueCross BlueShield South Carolina – Chief Design Architect
Walter.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
I'm very impressed with the testimony and thank you for all of the information and the work you're doing in the trenches really. My question might be more for Mat, but any of the other testifiers if you can comment that would be great.

At this point, it sounds like there is a lot of information coming from the Regional Extension Centers with respect to experiences and what they have heard and we are hearing some of the perspectives. Do you have sort of an assessment of these are the top five issues related to adoption and I would probably

categorize them in some way, like technology, work flow, workforce; is that something that you are already gathering and will be either reporting or are able to report?

So far, across the nation based on the experience of 60 Regional Extension Centers the top five issues, and they can be top five technology issues, top five workflow issues, is that something that you have and can comment on?

Mat Kendall – ONC – Director, OPAS
Yes, I think it's a great question because I think one of our goals is to aggregate all the information and then to provide it back to the public in terms of what we're thinking about and that's actually a goal for the HITRC, the Health Information Technology Resource Center. Currently we've been collecting a lot of the information from Regional Extension Centers in the various communities of practice. So, for instance, the Meaningful Use Group has been funneling a lot of meaningful use questions back to CMS and we've got great relationships back and forth. However, we did take some time this summer to aggregate the questions across all the RECs, which I believe is where you're trying to get to.

I think the initial areas, I would probably say three and I would then love to hear from Paul, or actually any of the other speakers to talk about their perspective. I think one was communicating about meaningful use in a program, just making sure that there is clear understanding of how this works, what the permutations are. Because this is a brand new program that's being implemented very quickly, there are a lot of timelines and that there is just a lot of information to get to providers and providers are hearing a lot of noise because they're trying to really be that definitive source of knowledge. It's very important and very difficult, frankly, to achieve.

I think another concern that we were hearing a lot about is, especially our rural providers, that there is a huge gap, there is a big gap that's forming. We're already heard about it at the critical access hospitals and it is becoming more and more acute to us. We implemented the Supplemental Grant really to address that, but I think there's a lot of work we have to be doing in that.

The third concern we hear a lot is about workforce, across the board that there are just not a lot of people who know all this stuff or who are seasoned and I think we're very excited about our Community College Workforce Program because the first set of graduates we have are quite amazing. They're had an average of 10, 15 years of workforce experience. These are not people right out of school; these are professionals coming into the field. We're looking forward to placing those folks and getting them out there, but in the future, I think we will be publishing more and more of the best practices and also questions that we're having because we need to get this information out to everybody.

Paul Kleeberg – Minnesota/North Dakota REACH – Clinical Director
As an Extension Center, to respond to you, in regard to the specifics of your group, one of the challenges that people see are the quality measures. Some of it really requires discrete data elements and documentation is not anything that's been part of, actually, the requirements for certification, so how do you get those quality measures in and how do you get them out. There is some controversy; you'll hear from Joanne Sunquist tomorrow on how impossible it's been, even for a large hospital with an advanced electronic health record to get the quality measures out accurately. So there are challenges on the quality measure front. How do small clinics build these? Theoretically, there will be a way to extract it, but what if they don't pick one of the three?

Exchange is another issue, especially in rural America. Who do I exchange with if the hospital is not ready and that's the only place I have to go to? They could be dead in the water. We've raised some suggestions that maybe the state Health Information Exchange needs to set up a bucket so that they can send sample data to the place so people have the opportunity to exchange.

The other one I think that's going to be pretty significant are clinical summaries. If you look at the number of elements that actually have to be in the clinical summary that means you have a complete chart; not

just one problem list, not just one problem, not just one medication, not just one allergy, but a complete list that you're handing to the patient as well as follow-up plans, labs, the whole deal. Some of the larger systems that have been doing it for a long time will be able to do that. For people who are just implementing electronic health records, that's going to be a significant barrier to get all that data in there in order to be able to do a clinical summary.

The last one I'll mention, too—and I don't know if it truly is a barrier, but it is a concern out there—is about eRx in small communities. Again, what if the pharmacy does not accept e-prescriptions, what does a provider do?

Anne Castro – BlueCross BlueShield South Carolina – Chief Design Architect
Joe?

Joe Heyman – Ingenix – Chair, National Physician Advisory Board
Well, I'm coming from the point of view of a small practice. I'm a solo practitioner and I have one employee and I've been using an EMR since 2001. It's a certified one and I've had e-prescribing for years and I've had a patient portal for years. When I figured out how much money I would get for implementing meaningful use next year, based on how much Medicare stuff I do this year, it's about $2,000.

I noticed in Mr. Gillett's testimony—actually, I noticed this last night—you mentioned that the relatively low expectations in the ambulatory setting are a barrier to achieving membership goals of the Regional Extension Center for those already on an effective system. I'm kind of surprised at that coming from my point of view. I don't see them as low expectations and I'm just wondering whether the other members of the panel agree that these are low expectations. Also, maybe Mr. Gillett you want to respond.

Clayton Gillett – O-HITEC, Oregon's Regional Extension Center – Executive Director
Let me clarify for just a second there. I would say that the context of that statement is to the extent that you already have a system up and running, we see that many of the people who have systems up and running, we expect them to certify very quickly in the state of Oregon. I think there is a divide here between the people who were the first movers, who invested heavily in systems and they did invest heavily, more than you do today when you implement. They have spent time working on these systems and working out the bugs and figuring out how to capture a lot of this information and do quality improvement. I think their leap is a lot smaller than folks who haven't implemented systems yet and that's what I was referring to.

Joe Heyman – Ingenix – Chair, National Physician Advisory Board
But I guess my point is, if you're looking at really small practices like mine, it's going to cost me more than $2,000 to go from where I am now, which I believe is a very meaningful way of practicing, to meeting meaningful use requirements.

Clayton Gillett – O-HITEC, Oregon's Regional Extension Center – Executive Director
I think the question there, if I may, I think the question there is more about technically meeting the requirements as opposed to meeting the intent of those requirements, too, to a large extent. Is that correct in what I'm suggesting, because I think the technical requirements are much harder to meet. You can be meaningfully using a system; an old system that's not certified and not upgraded and still has a better system than someone who has implemented just now a fancy new certified system that supposedly has all the bells and whistles.

Joe Heyman – Ingenix – Chair, National Physician Advisory Board
I guess what I'm asking is do the rest of the panelists agree that this is a low goal, a low bar? I agree that it's a lot better than what the original recommendations were, the original stuff that was put out there, but I don't see this as a low bar for small practices. If somebody like me, who has been using this for years, finds this a difficult situation, it seems to me that somebody that's never been using it and is in a single or

double group practice is going to have even more trouble getting there. So, that's really what my question is.

Paul Kleeberg – Minnesota/North Dakota REACH – Clinical Director
If I may respond, too. I agree that the smaller practices, the ones that aren't affiliated with some system in some way, shape or form, there are certain elements within the meaningful use criteria which are going to be a particular challenge. But I'm certain you've got your problem list filled out, I'm certain you've got your medication list filled out, I'm certain you're using your electronic health record and really using it quite effectively.

I think when Clayton and I talk about the large number of people that will be successful; they're affiliated in such a way so that the Health Information Exchange and some of those other particular challenges that will be difficult for the small independent practice are already taken care of. I think what you're bringing out is you're emphasizing sort of that information divide that we used to talk about with the Internet years ago; there were the haves and the have nots and the small, independent practice is part of the have nots and that's really the population that the Extension Centers were meant to begin to address.

Those are the types of tools, the types of things that you need are the types of things that the HITRC (the HIT Resource Center) are trying to develop for us Extension Centers to bring to you so you can achieve that. I'm surprised you only have $2,000 worth of incentive; my heart goes out to you. But, you know, once you are actually able to exchange with those other providers with whom you are referring patients, you're going to see a lot more cost savings in terms of paper and other things that will pay you back. So, maybe you won't get the incentives, but you will, I believe, get efficiencies that will help you in the long run.

Anne Castro – BlueCross BlueShield South Carolina – Chief Design Architect
I think I'll transfer now to another question. David?

David Kates – Prematics, Inc. – Vice President Product Management
Thank you very much for all the testimony. It was very informative and I think helps in putting some tangible examples of what's going on out in the real world. In both the oral testimony and the written testimony that both Mr. Nelson and Mr. Gillett submitted, you made some comments today and in that written testimony regarding—and to some extent this last conversation—about the plethora of certified EHR systems that are going to be put out in the marketplace. The concerns that you've expressed in terms of there may be a buying frenzy of small practices that believe they're going to get more than $2,000 and achieve that meaningful use and possibly be saddled with something that isn't going to get them to stage two and stage three. Can you give some specific examples of where you think those concerns are and what role the RECs can play in helping alleviate that, and the committee and the Standards Groups can play in helping establish some bars for avoiding some of those concerns?

Dan Nelson – Desert Ridge Family Physicians – Practice Administrator
My comments were more related to what my hopes for stages two and three will bring to a practice such as ours. We've got a real good head start. We've been using a certified EHR for six years now and so the jump to meaningful use is going to be rather low for us. What I would hate to see is a whole bunch of practices go and adopt certified EHRs, reach stage two and three and really have no ability to connect to an Exchange and remain being these islands of care that have a very hard time communicating amongst each other.

David Kates – Prematics, Inc. – Vice President Product Management
Mine categorically is, are you focused primarily on the interoperability aspects and seeing some early visibility into the capabilities with regard to the vendors in that regard?

Dan Nelson – Desert Ridge Family Physicians – Practice Administrator
That would probably be the item that I'm most concerned about is interoperability.

Clayton Gillett – O-HITEC, Oregon's Regional Extension Center – Executive Director
I would comment a little bit; I mean the interoperability is an issue, but the basic functions of the EHRs, several of them which are certified are very different in their sophistication, extremely different. An example is how you document an allergy in one system is it's an allergy, period. It doesn't say whether someone is going to go into anaphylactic shock because they got this allergy. It doesn't say that this is a patient reported allergy, which may not be real. It doesn't say that this is a provider allergy.

This is a certified system. This is a discussion that at our Meaningful Use Committee when we started talking about allergies. Those are very different systems and the effectiveness of those systems are very different. We have to find some way to tell somebody, to tell an individual provider in Enterprise, Oregon, which is a very small community, that you're buying a system that is certified, but maybe it has some score that's different than some other systems so they can justify spending what's going to be useful for them in five years.

We're seeing in Oregon that the people who bought systems three years ago are junking the systems they bought, and this is not a minor issue for those providers. Some of them are getting $2,000 and they're still saying I can't use this system long-term. That's a huge expense and a lost opportunity for this committee and these policies and it needs to be addressed.

David Kates – Prematics, Inc. – Vice President Product Management
Do you feel the RECs are constrained in their ability to make those?

Clayton Gillett – O-HITEC, Oregon's Regional Extension Center – Executive Director
RECs are hugely constrained in giving clear advice about what systems they feel are appropriate. The ones that are QIOs can't give any advice, hardly, the RECs that were QIOs before. The other RECs—and I've heard this discussed at length among the RECs, well, we're afraid that we're going to get sued by the vendors. A lot of times, this is an expert opinion, as well, and if you stand out there with your expert opinion, you are increasing your risk.

Paul Kleeberg – Minnesota/North Dakota REACH – Clinical Director
If I may respond, too, as another Extension Center—because I did mention at the end of mine a concern about the record systems. I think one of our jobs as an Extension Center— We are vendor agnostic, but we spend a lot of time with our clients upfront in helping make sure that they make a very critical and clear decision and why they want to make a decision about what vendor they go with. And among the things having to do with the stature of the vendor, how long they've been in business, their user base, etc., because those all go into a business decision. You just don't go based on price or else you get something that breaks in a few months. The other thing that I do advocate is that, as I mentioned, the CCHIT criteria that were recently developed, they were very specific about elements that could be in that record system.

I would consider that the Standards Committee think about some of those elements in there. There are no documentation standards and I know you wanted to keep the first step on the escalator, as Dr. Blumenthal says, relatively low, but I think we need to get some standards in there. Or else some people who don't have the advantage of having an Extension Center that helps them plan well may wind up going for something that's cheap and affordable and wind up in a dead end later on. That would be terrible.

Anne Castro – BlueCross BlueShield South Carolina – Chief Design Architect
Okay, I think we've come to the end of that run. Liz?

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
I just had some questions for Dan. I'm reading your testimony. There are a couple of examples that you gave that I found interesting I'd like you to expand on in terms of things you did that worked. You

identified first that you had an association with a university to do testing; do you want to talk about that, please? The second thing is you have evidence-based medical opportunities that apparently came from the RECs, can you talk about those, please?

Dan Nelson – Desert Ridge Family Physicians – Practice Administrator
For the intern testing, that hasn't begun yet. When we first put our new version into our test database, we will be working with ASU and a specific intern to come out and do a full battery of testing to make sure it's going to do what we need it to do. We won't have any hiccups once we take it to production. This is something we would be doing ourselves normally, and have done in the past, but the real advantage of doing it through ASU and through our REC is that they can then use that experience and transfer it to another practice. They can eliminate pages of testing protocols and say this has already been tested, it's bullet-proof, there's no reason to worry. Let's move on to this area where interfacing was an issue and let's test those interfaces a little bit more thoroughly than we did at Desert Ridge. So, I think we'll be able to save a lot of time and effort and share that knowledge.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
And before you answer the question about the evidence-based, from the RECs perspective or the other providers, what are you doing for testing? We're really looking for a concept that can be shared from the REC to other rural providers and they're looking for answers, so what are the RECs doing, what are the other providers doing in the testing area?

Dan Nelson – Desert Ridge Family Physicians – Practice Administrator
Is this also for me?

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
No, Paul or.

Paul Kleeberg – Minnesota/North Dakota REACH – Clinical Director
Actually, when I read his written testimony I thought that was an excellent idea and I forwarded it to our REC, because I thought that was a very good way to use interns. So, again, we don't have any specific plan around the testing because a lot of the work that we have done is around giving people the tools for them to do the work, but I think that's very cool. I was very impressed.

Clayton Gillett – O-HITEC, Oregon's Regional Extension Center – Executive Director
I would just say really quickly that we have made sure that people do testing and work with their vendors to get testing materials, but it is true that some vendors do not have those testing materials.

Mat Kendall – ONC – Director, OPAS
Just building off of this, I think one of the things that we're trying to is get the Regional Extension Centers to work with the other ONC funded grantees in different states, for instance, the HIEs or the state health IT coordinators to come up with plans. If you look—I know you're discussion this tomorrow, but—they are actually in the process of trying to come up with a comprehensive plan. We're trying to make sure we're supplementing the work that they're doing with RECs using purchasing power, economies of scales an REC might have to support some of the processes they need to, because this is of exchange is very important for meaningful use. We need to make sure it's going and in the rural areas, there can be huge challenges around this.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
Well, when I read Dan's testimony, the reason I brought the question up is because I know that testing is an area that people are struggling with and so we're looking for innovative ideas and we're looking for the RECs to be able to provide that to our rural participants. Dan, do you want to talk about evidence-based medical opportunities?

Dan Nelson – Desert Ridge Family Physicians – Practice Administrator

Our experience with evidence-based medical opportunities was prior to working with the REC. It was part of a pilot project that we had participated in and I thought there were some good experiences so I wanted to share that in my testimony. I think that was part of our education on why these goals of the modernization of healthcare are so important. We were able to use those evidence-based medical opportunities provided by an insurance company and put them right into our electronic medical record and so that our providers could act off of them at the point of care.

We do get evidence-based medical opportunities now, but they get faxed to us or get mailed to us by insurance companies and we have no way of inputting it into our electronic health record system. We also have no way of filing other than, perhaps, scanning in and waiting to act on them.

So, the way that we were able to work with this insurance company through this pilot project was, in my mind, kind of an ideal way of working with these evidence-based medical opportunities. At the end of the pilot, there was really nowhere further to go. The experiences of the other participants in the pilot program put in so much work that it was too hard to duplicate and there was really no way to deploy this on a wider scale. However, if there were enough practices that were electronic, interfaces could be built so that this type of information could be shared through our practices and we'd have a very efficient delivery of this type of information.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
Great. Thank you. Judy?

Judy Murphy – Aurora Healthcare – Vice President of Applications
Lisa, I'd like to pose a question to you. You were talking a fair amount about the cost of participating in the Regional Extension Center, particularly the per provider cost. After you went ahead and spent that money, did you feel you got the value from it or is there an alternative financial model that you think might be more acceptable, particularly for the community health centers?

Lisa Levine – Family Health Center of Worcester Massachusetts – Vice President, Operations
I don't know if it's worth it because we are still actually waiting for our contract for our IOO and the REC, I believe, is still in Massachusetts, trying to enroll providers and get stuff moving. I'm hoping it's going to be worth the funding because I think that we really do need the help. We need somebody that can walk us through testing. We need somebody who can help us with the interface and all of the things that come with implementing an EMR I think that's the reason why we thought we needed to spend; whether it's going to be well spent will remain to be seen as this rolls out of Massachusetts through the year.

Judy Murphy – Aurora Healthcare – Vice President of Applications
I believe that's a state-based decision, is that correct, guys?

Lisa Levine – Family Health Center of Worcester Massachusetts – Vice President, Operations
My understanding, and I don't know the specifics, is that I believe that there are other states that have done things differently with community health centers. I don't know the specifics, but that was not the case in Massachusetts, although I think that there was a lot of talk between the Mass League and the REC to try and come up with something that would work. I mean there are 48 community health centers in Massachusetts. It would have been nice if they could have seen a way to look at this particular body of providers a bit differently.

Judy Murphy – Aurora Healthcare – Vice President of Applications
Then just from a process standpoint, and I think this is to Mat at ONC, is this the type of discussion that would end up getting vetted back through the Regional Extension Resource Center? Or, are these experiences just they're experiencing it and that's just the way it is?

Mat Kendall – ONC – Director, OPAS

No, I think these are exactly the types of things that there is actually a community practice on sustainability. Because one of the charges that we have for the Regional Extension Centers is that in the long run they have to be self-sustaining. There's a body of research that illustrates that if people take something that is "free" they don't value it enough and when you're going through something as difficult as an EHR implementation, that you're going to not, at some point, just stop.

So, there is finding that balance of some things the Regional Extension Centers are talking a lot about. There were some cost share requirements on our end that we initially put into the grant that we've lightened recently in lieu of some of the feedback that we've gotten from the Extension Centers, but certainly there is a robust discussion about this.

Judy Murphy – Aurora Healthcare – Vice President of Applications
Thank you. Paul?

Paul Egerman – Software Entrepreneur
Thanks, and I want to echo what everyone else has said, I really appreciate this testimony. It's very helpful and actually, my question was almost the same as what Judy just asked. I was very interested and concerned about the pricing situation that you have, Lisa, in Worchester, but what I'm curious, though, is I suspect the reason the pricing came out the way it did was because, you know, you say you have roughly 35 providers. Those are really a lot of part-time people, is that correct?

Lisa Levine – Family Health Center of Worcester Massachusetts – Vice President, Operations
They're the equivalent of 17 full-time (17 FTEs) and I think that may have been part of the reason why they did it. I also think that there is a sustainability issue for the REC and Massachusetts, although we have a maldistribution and some under-served areas, we're a big doctor state and this was a really, if you think about $600 a primary care doc and $800 a specialist, it's a good way to bring in some money. For some of the organizations we have in our state who have very, very deep pockets, it's not a problem.

Paul Egerman – Software Entrepreneur
That's interesting. So, you say 17 providers, so you're roughly triple the size of Dan Nelson, sitting right next to you, is that right?

Lisa Levine – Family Health Center of Worcester Massachusetts – Vice President, Operations
Yes.

Paul Egerman – Software Entrepreneur
Did you pay like $7,000?

Dan Nelson – Desert Ridge Family Physicians – Practice Administrator
In Arizona, because we are a small practice and in primary care, we did not have to pay anything to our REC.

Paul Egerman – Software Entrepreneur
You paid zero?

Dan Nelson – Desert Ridge Family Physicians – Practice Administrator
Zero.

Paul Egerman – Software Entrepreneur
Okay, so she paid more than three times that amount.

Lisa Levine – Family Health Center of Worcester Massachusetts – Vice President, Operations
Exactly, and I'm going to send Dan the bill for his share.

Paul Kleeberg – Minnesota/North Dakota REACH – Clinical Director
The way the regulation is written is that the providers are supposed to pay 10% and 90% was supposed to come out of the subsidies. Now, that 10% share is possibly part of what worked out to be that amount that Lisa had to wind up paying, because if you say $600 per provider, roughly getting $5,000 per provider in subsidy it works out to be a little bit more than 10% when you come down to it. But when you look at what RECs have to do, and I can say in my state or one of my states, North Dakota, we have average of two or three physician practices sprinkled 50 or so miles apart. So, if you're going to earn $15,000 to take a small practice and a year of working with them to bringing them to meaningful use, you'll lose your money there. So, we can't do charity. We have to somehow work this all out.

Now, why some organizations can charge nothing for the match component, they're able to get matches from other places. For example, North Dakota is covering the match for some of the providers in North Dakota. Some QIOs have an alternative business source for their match dollars, so it doesn't have to necessarily match come from the providers; it can come from some other business source. So, for example, in North Carolina the QIO there, which is also a REC, an Extension Center, has been doing quality improvement with clinics for a number of years and that quality improvement has been subsidized by the health plans in the state of North Carolina. Well, they have latched on this, the REC program on top of that and they're calling the match dollars the stuff that they are getting from the health plans.

The issue is, and I understand the confusion here, is because each of our Extension Centers were charged with coming up with our own pricing structure and our own way for doing things. So, what you hear is confusing and as about as confused as we were when we were starting, but that is what it is right now.

Judy Murphy – Aurora Healthcare – Vice President of Applications
All you have to do, Lisa, is relocate to North Dakota or Arizona.

Dan Nelson – Desert Ridge Family Physicians – Practice Administrator
Yes, I think the other thing that's true is there are kind of three categories of people who are Regional Extension Centers. There are the QIOs kind of as one big category; there are some implementers like OCHIN, who were already a health center control network or some other reason they were supporting a bunch of clinics on a hosted solution.

Then there is kind of the universities kind of approach. I may be wrong, but that's kind of generally how it is and those three groups kind of took very different tacks in how they built that business plan out for obvious reasons; because their business that they already had, there was a fourth group, actually, that didn't have any organization whatsoever, that had to be built up. So, they had very different requirements as well. So, I think it's appropriate for the history of those organizations to some extent, but I do feel bad for you.

Paul Egerman – Software Entrepreneur
I just want to follow up on what you said, Paul. Is it correct coming to the conclusion to say well, gee, what they did in Massachusetts to charge $21,000 for these people is not unreasonable? Is that?

Paul Kleeberg – Minnesota/North Dakota REACH – Clinical Director
It's not unreasonable, is that what you're asking me?

Paul Egerman – Software Entrepreneur
Yes.

Paul Kleeberg – Minnesota/North Dakota REACH – Clinical Director
For the per provider services that they should be getting, they're paying $0.10 on a dollar for roughly what they're getting specifically, should be. So, as Lisa said, she'll see what services have come, but that's the goal behind it.

Mat Kendall – ONC – Director, OPAS
I think the interesting thing about the Extension Center model, in general, is you're seeing different models that are developing to address the local needs of what's happening in different states and Massachusetts, North Dakota, different states, different environments, different resources in play.

From our perspective at ONC, I think there's an opportunity for us to look across the country and see where the success is in different models because everybody has to go through the same milestones. So one of the things that we're doing is collecting a lot of data from the extension centers about who they're enrolling, what kind of practice they're in, where they're located and this is information that will ultimately be public on our Website as we get going because, I think, we've got to see which models are successful. The different pricing is clearly a factor, but I think the question of value is really what it comes down to because there's a huge need for these comprehensive services and if it's something that is valuable to providers, then people will pay for it, clearly.

At the Extension Centers, we're just trying to get the starting dollars going to let people develop this business proposition, but it is something that is probably the hottest topic we have is how do we make sure the value proposition is there? How do we get the services to providers, because, especially, in the small practices there are just a lot of other things going on and we need to be sure we have a clear value proposition.

Paul Egerman – Software Entrepreneur
But Lisa's environment is more than just a small provider environment; it's a qualified health center. It would seem to me that we should be having a structure that does our best for that population.

Mat Kendall – ONC – Director, OPAS
I think, again, there are different models in different places about this. I mean, I think some of our RECs from federally qualified health centers charge on FT basis. Some of them don't charge; some of them charge fees like this. I think we're seeing success in all different models to a certain point. I think the reality is enrollment is just the easiest first step. It's going to be how we get people to EHR certification and … three ultimately. If the value is there and the services are in place we'll see people getting there and the data will help us ….

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
So, Mat, this is Liz, from a grounding perspective then, as I listen to Paul's and Judy's questions and then Clayton you alluded to there are different types. Can you just go through; are there four types of RECs and what are they?

Mat Kendall – ONC – Director, OPAS
There are 62 Regional Extension Centers and they do break down into four types along the lines of what Clayton said. I would maybe refer to them slightly differently, but I think it's the general gist of the same. First of all, we have a lot of organizations that are also Quality Improvement Organizations (QIOs). A lot of great work was done with the docket programs being leveraged going forward. In another setting, we have our sort of university research component and that takes a little different flair. Each place does it slightly differently, but sort of embedded into an academic institutions similar to the Agricultural Extension Program.

The next one really that we have is a group of organizations that are committed to doing Health Information Exchange and implementation. These are organizations that sort of have, we call them twofers, because they also have an HIE grant in some states and a lot of these are new organizations so the Extension Center part may be something brand new that they're going through and implementing.

Then we have this other category, which I think encompasses about a fourth of the groups in it. It includes our health control networks, so we have wonderful health control networks that have a lot of

experience doing this. These are HRSA funded programs historically that have worked with FQHCs specifically. We have a couple of managed care companies that through their foundations are implementing this and, again, it's a different approach in terms of what they're doing. Then finally we have some just foundations, organizations that have sort of spun off an element of this.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
Do you have responsibility to manage and report on all of those types?

Mat Kendall – ONC – Director, OPAS
Everybody reports all the milestones on a regular basis. So, we are monitoring this on a daily basis. So, I can tell you, for instance, I think there are 1,700 folks, providers, in Massachusetts that have been enrolled, high FQHC numbers. Other states, we have out of the 35,000 about 10,000 are FQHCs right now, largely because I think there is a resonance among this program in the Federally Qualified Health Centers.

We've got 35% that are small practices and if you look at the consortium, and we're finding an interesting trend in the Midwest where a lot of historical small practices are now banding together under one tax ID. This is something we didn't know about initially, so we had to change our regulations to sort of encompass that. It's a change in the healthcare world we're seeing, so that's another fair chunk and then public hospitals coming on board.

Critical access hospitals: We're targeting 1,654 critical access hospitals across the country with 25 beds or less. We know who they are, but getting the services and getting the support to them, it's significant and that's why we're adding additional funds to the Extension Centers working with those populations.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
Go ahead, Joe.

Joe Heyman – Ingenix – Chair, National Physician Advisory Board
In Massachusetts, we have almost every one of those kinds of suggestions that you just made; each one of our COOs are those things and then we have this umbrella thing that doesn't really do much. I don't know what it does other than collect the money and distribute to the COOs and I guess it plans what the projects are, but we actually have university types that are COOs, we have physician networks that are COOs, now here we have an organization that's a COO. We have an implementation private company that's a COO.

Judy Murphy – Aurora Healthcare – Vice President of Applications
I think what I'm hearing is if you've seen one REC you've seen one REC.

Joe Heyman – Ingenix – Chair, National Physician Advisory Board
Exactly and my IPA, we're using this implementation company as our COO for the REC. So, we've got a whole bunch of choices and some may be more effective than others and I don't know how you're going to measure all that.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
Do you have any public reporting on the expectation versus the reality on each of these different 62 RECs?

Mat Kendall – ONC – Director, OPAS
Absolutely. So, at a very minimum there is a set number of a thousand to 6,000 providers that each Regional Extension Center is responsible for getting to the three milestones. We will be publishing those numbers and where they are in term of their milestone one, which is recruitment. We'll be putting milestone two and milestone three on once we start collecting that data, but I think there's a lot of transparency and going back to your point about evaluating the different models, we are seeing Regional

Extension Centers doing a whole host of; some of them are doing channel partner marketing, some are doing regional marketing. It really depends on the market environment they are because, again, different communities are different and want to have the flexibility to put up different models.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
Mat, one of the questions that comes to mind when you say that, if I were a consumer like Lisa or Dan, I would like to be able to go to something on your Website, do a quality and cost evaluation and make a choice. So, I think that's what we're asking for.

Mat Kendall – ONC – Director, OPAS
Yes, the Regional Extension Centers are geographically located.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
Right, I understand that.

Mat Kendall – ONC – Director, OPAS
So, in the geographic location an Extension Center has to have choices about services and things along those lines. You can get to them from the ONC Web page; you can link to the Extensions.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
So, what you're saying then—so let me clarify—we don't have a choice where I reside. We have to participate. There are five in our state, in that we participate in the one that we are geographically aligned with. We just happen to be in all five of them. So, you're saying Lisa can't go to a university. If she has a designated REC in her area she must participate.

Mat Kendall – ONC – Director, OPAS
Yes, and each REC, no matter what type of entity you're from, has to provide the same core set of services, get them through the same milestones, things along those lines.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
But they're not required to use the same pricing models?

Mat Kendall – ONC – Director, OPAS
No.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
So, maybe I'll risk opening up this to other areas where they could be sharing—so, great discussion about we're trying lots of things and hopefully we're learning about some of what's working, what's not working and clearly finances is a hot topic here. Are there other things that you feel have been really hot topics that there has been a lot of activity among the RECs in terms of things that they've been learning that are worth sharing?

Paul Kleeberg – Minnesota/North Dakota REACH – Clinical Director
I mentioned a lot of them in my statement. One of the things I do want to draw out is because of the very short timeline I think some of us felt like it was ready, shoot, aim. We really had to get people signed on to meaningful use. In our particular instance, we received notification that we were going to be a REC in February of 2010. We actually got some dollars to hire staff in April or May of 2010, so then we hire staff and begin to train the staff. Then begin to get those staffs out there to talk about the model that we have had in order to work with the clinics and get clinics signed on and we really had to get a lot of people signed on. So, a lot of our energy was spent in the first period of time trying to get customers. So, here we are asking for them to give us money because we helped get them to meaningful use. I'm from the government; I'm here to help you. You know, that went over like a lead balloon. So, it took time to build trust.

Once we had trust built that helped. As I mentioned, around October 18th, then we actually got a clear definition of these consortia because we're in the Midwest where all these clinics had banded together in order to survive and we wound up not being able to work with almost two-thirds of the providers that we had in our initial contract. So, one of the things that I think that is helping us and also I think will address the issue that was talked about earlier, money, is that that subsidy—although it was intended for only two years. Although we had to have everybody signed up that was going to be part of our program by the end of this month—that program has been extended another two years.

Now, we have to prove that we're meeting our milestones; we have to prove that we're doing a good job, so there is going to be some quality assurance in here for us to be able to continue on with the process. Those RECs that are not successful will not get their contract renewed for those two years. We also have to apply for the increased funding for the critical access hospitals. So, that has helped a great deal in terms of this urgency that we had in the beginning to just build customers. I think that's one of the reasons, Lisa, why you haven't felt as much delivery of services because the RECs were so busy desperately trying to sign these customers up that they agreed to and training their staff on the methodology that they would use to be able to use with these folks.

Now, remember, the Workforce Training Program was supposed to be people that were going to be staffing our Extension Center Program. Well, they're just graduating now. We already had to have our program in place. So, Larry, I'm not sure if I answered your question directly, but I think it's important learnings that we've had and the timeline has been helpful for us in two different ways.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
I guess I'm hearing that there's a lot of start-up problems in terms of the pace at which things happened. You could also apply that same thinking, I think, to some of the meaningful use criteria and the certification process of we want a place where everybody can start, but we may, in fact, be creating unintended consequences by doing that.

Paul Kleeberg – Minnesota/North Dakota REACH – Clinical Director
The Resource Center that was developed has really helped a lot in bringing up to speed those folks who haven't had knowledge and shared tools across them. So, yes, there was a flurry in the beginning of what do I do, what do I do? But I think that HITRC, that Resource Center, is really helping us significantly. So, the extension in timelines, although that was one of those; although the rapidity with which we started created problems, I think now we're headed for a much firmer track, given the opportunity to continue for two years, which is much more in accordance with what the clinics' and hospitals' timeline is.

Mat Kendall – ONC – Director, OPAS
Just to follow up on that; our first REC is not yet a year old, so I think there are a lot of lessons that are still going to be coming out shortly. I think a lot of the things that we've been hearing, lessons learned, are communication tools, getting the right message to providers so we can be very clear about what meaningful use is, what a certified system is. We didn't have those things until different stages of the year. I think getting that message out is very important.

I think the next thing is really beginning to partner with vendors in thinking through how to implement systems. This is a lesson learned we're developing and I think it's really important because it's a shared win across the board. Then the third area is really beginning to think about Workforce, not just for the RECs. The Community Colleges definitely will benefit the RECs, but our goal is to get 10,000 students out annually, which I think will exceed even the capacity of the REC's staffing needs and really get those students or these new workers into practices, into organizations, working with vendors. I think we can't get them out fast enough and we're looking forward to doing that. It will be good for us.

Anne Castro – BlueCross BlueShield South Carolina – Chief Design Architect

Okay, I'm going to exercise moderator advantage and ask that you provide the Websites for the RECs and where the ONC will report on their progress.

Mat Kendall – ONC – Director, OPAS
That will be on the ONC Web page, under the Regional Extension Center page.

M
It's healthit.hhs.gov.

Anne Castro – BlueCross BlueShield South Carolina – Chief Design Architect
That should have rolled off your tongue.

Mat Kendall – ONC – Director, OPAS
I think in terms of the next question about where the dashboard is, that will be linked to our Website. We're still in the process of developing that interface.

Anne Castro – BlueCross BlueShield South Carolina – Chief Design Architect
And we're expecting that when?

Mat Kendall – ONC – Director, OPAS
That's a timeline that's outside of my control, but I think the first instance, for instance, a static summary we'll have by the end of this month of just some of that stuff.

Anne Castro – BlueCross BlueShield South Carolina – Chief Design Architect
Okay, so healthit.hhs.gov. Then for the purpose for listeners today, the REC Centers represented, your Websites?

Paul Kleeberg – Minnesota/North Dakota REACH – Clinical Director
Mine is khareach.org.

Clayton Gillett – O-HITEC, Oregon's Regional Extension Center – Executive Director
O-HITEC is o-hitec.org.

Anne Castro – BlueCross BlueShield South Carolina – Chief Design Architect
Thank you. I'm also going to continue with my question. First of all, I'm a little stumped. Earlier we were talking about how you can or you cannot help physicians with vendor selection. I'm not clear on that because in South Carolina I spent some time with our REC helping them with vendor selection to get a priority list of vendors with a better licensing agreement going through the REC. So, I'm a little confused about that. Mat, if you can address that?

Mat Kendall – ONC – Director, OPAS
Absolutely. Again, the business models of each REC and the decisions that they make are the REC's decisions. From the ONC perspective in the FOA (the Funding Opportunity Announcement) that we released it spelled out that we did want RECs to explore different ways in which they could do licensing with providers to get economies of scale.

I think there has been a wide range of interpretations on how to do that. Some organizations had preferred providers that they had been working with. Other organizations had said, you know what, we're going to work with all providers. I think the critical point about all of this is it's about focusing on the needs of those small providers and making sure they get what they need. So, even in instances where someone may be vendor agnostic, they're still focusing on what are the things that we need to make sure that are in every contract? What are the interfaces that are required? Are there ways of doing that? And I think people described it in different ways.

I think from our perspective we just have to follow the rules that are outlined in the Federal Procurement Rules, things along those lines, but we want to give the RECs, again, the ability to leverage across the board. I think one of the things we're seeing that's very interesting is there is a lot of flexibility in local markets. There may be someone who is already doing a program and RECs are coming to support that, leverage that work rather than compete with those initiatives. I think that's what we're looking for because we're looking for, really, the funds we have we want to get every provider in the country to meaningful use and we just have to figure out a way of stretching it as far as possible.

Clayton Gillett – O-HITEC, Oregon's Regional Extension Center – Executive Director
Can I take a stab at that as well? In the state of Oregon, because we are 65% installed and we already have it, so we have vendors in each area that are dominant. So, in certain towns, certain areas, Allscripts may dominant, or NextGen may be dominant, or Greenway or GE, since GE was created in Hillsboro, which is outside of Portland, Oregon. So, we felt like there's a huge amount of investment by providers already and we want to support that investment. We want to make them successful on the tools that they have right now if they want to stay on those tools.

So we've made decisions that are probably different than some of the other Regional Extension Centers because we want to support those folks that are already there. These are all great products that are out there, that are used by a large number of providers in our country and many of them are certified or will be certified soon.

Anne Castro – BlueCross BlueShield South Carolina – Chief Design Architect
But I also heard loudly the concern about those who retain an existing provider under meaningful use one might not necessarily be in a good position or any position for two and three and that that is something that can be measured now in terms of a vendor that's on a path to making themselves successful. So, I would be concerned that that piece of information isn't one of the highest regarded value adds from the Regional Extension Centers. Of course, that's my opinion. But vendors are going to consolidate and there will be a lot of reduction over time, so I think that's a very important issue from the get go, no matter what size the provider is.

Clayton Gillett – O-HITEC, Oregon's Regional Extension Center – Executive Director
That's a really difficult thing to predict, though. Even for people who have been in the business for 15 years, who have been doing implementations. How many people five years ago would have guessed that Misys.

Anne Castro – BlueCross BlueShield South Carolina – Chief Design Architect
It's hard to get a volume discount if you don't get it down to a few, though.

Clayton Gillett – O-HITEC, Oregon's Regional Extension Center – Executive Director
Well, in our state we don't believe we're going to get significant volume discounts anyway. There are just not enough people implementing.

Paul Kleeberg – Minnesota/North Dakota REACH – Clinical Director
If I may respond to your question. We were going to come up with a preferred provider list and as a QIO, we theoretically couldn't, so we were going to outsource that and after the lawyers got done looking at it.

Anne Castro – BlueCross BlueShield South Carolina – Chief Design Architect
Oh, you shouldn't have done that.

Paul Kleeberg – Minnesota/North Dakota REACH – Clinical Director
I know. It was right before our timeline was going run up so we figured it was not worth it. But there have been Extension Centers whose rationale for selecting EHRs were requested by a law firm. So, consequently we were saying we would not want to be caught in litigation because we chose one vendor

over another, so potentially a vetted process. So, it's not just simply picking vendors. There are risks to it, so to speak.

Anne Castro – BlueCross BlueShield South Carolina – Chief Design Architect
My last question is have any of you on the panel—including ONC, probably more so, ONC, Mat—considered a national campaign of education on this nasty, nasty, complicated topic? Because I haven't found anybody who knows what I'm talking about when I talk about what I do for my part-time job.

Mat Kendall – ONC – Director, OPAS
Absolutely. I think, actually, ONC on a communications perspective, we have the new contract that's in place to really do the education about the value of meaningful use across the board, things along those lines, from a Regional Extension Center perspective. We're beginning to roll out materials that describe more succinctly in a detailed fashion. We're learning from our colleagues in the pharmaceutical industry about how to get the information to providers that are very succinct to try and boil this down.

We've got a lot of great lessons learned from the Extension Centers about how to engage different segments of providers because different messages resonate differently in different groups. So we're trying to get all that information across the board and I think that we're also working very closely with our colleagues at CMS because the dollars are beginning to flow and that's very important news. CMS has done a great job of working with states to get AAU programs up. I think we want to celebrate all of that because there's concern that it's not going to happen and in reality it is happening. It's getting out there and there are going to be a lot of people benefitting from it, but we definitely need to continue the national campaign.

Anne Castro – BlueCross BlueShield South Carolina – Chief Design Architect
And I think, don't lose sight of the patient and their education because they'll be part of the success or failure of this in terms of what they demand when they go into a physician's office, so that's a key ingredient. I would finally say that you probably have a year to do this, because then the shadow of the Exchanges will be over this topic and then it will be a whole other level of education that has to be achieved, so thanks.

Did you still want to ask a question, Robert?

Robert Anthony – Centers for Medicare & Medicaid – Health Ins. Specialist
Actually, Paul's comments, his last comments addressed my question.

Anne Castro – BlueCross BlueShield South Carolina – Chief Design Architect
Okay, thank you. Judy?

Judy Murphy – Aurora Healthcare – Vice President of Applications
So, complex was the word used most frequently in all of your testimony, specifically related to all sorts of things, but mostly around the meaningful use requirements and the registration requirements and settling this down. So, I got the sense that everybody agreed that the RECs were providing a wonderful service in being able to vet that all out for the average small provider and that that was a really helpful task. However, I'm just curious. Do you all have people that are going to be certifying in 2011? So, Lisa, specifically, are you guys going to be able to qualify in 2011?

Lisa Levine – Family Health Center of Worcester Massachusetts – Vice President, Operations
Oh, yeah. We have no choice. I think the hard thing, and it was sort of mentioned earlier, is you sort of feel like you're chasing a racing train and it's really hard trying to keep up. This is like moving the Titanic, at least at the point of care where I am. Yet, at the same time, we know that we're charging towards the finish, we have to get to that finish line. In Massachusetts, we have to get to it because if we don't have providers certified, they can't practice medicine. That's a huge, that's the acute problem.

Judy Murphy – Aurora Healthcare – Vice President of Applications
So, you're going for it. Dan, are you going for it in 2011?

Dan Nelson – Desert Ridge Family Physicians – Practice Administrator
Yes. I have no doubt in my mind that all of our providers will be certifying in 2011.

Judy Murphy – Aurora Healthcare – Vice President of Applications
Paul, do you have people that you've been working with that are going to be able to qualify?

Paul Kleeberg – Minnesota/North Dakota REACH – Clinical Director
Yes, we will, but those are people who already have EHRs in place. For those who came to us on paper, they won't be qualifying in 2011.

Judy Murphy – Aurora Healthcare – Vice President of Applications
Because you're helping them select.

Paul Kleeberg – Minnesota/North Dakota REACH – Clinical Director
Correct.

Judy Murphy – Aurora Healthcare – Vice President of Applications
I think you had that, actually, in your testimony. How about you, Clayton?

Clayton Gillett – O-HITEC, Oregon's Regional Extension Center – Executive Director
Yes, we have several IPAs as well as our own installed base that we'll meet in 2011. Like I said, we're a little different in the sense that so many of them already implemented, but I will say that I don't believe we'll have a critical access hospital make it. I do believe that for those, especially in the rural settings who have chosen to implement their own system, host it themselves, those kinds of things, they're going to have a little more difficulty and it will take them longer.

Judy Murphy – Aurora Healthcare – Vice President of Applications
So, again, it would have to be somebody who already had an EHR. Do you have some providers?

Clayton Gillett – O-HITEC, Oregon's Regional Extension Center – Executive Director
Not just have an EHR, but maybe even— There's an issue we really haven't talked about here yet, which is kind of the discussion of what's hosted and what's not hosted and how can the rural organizations really manage this complex kind of technical infrastructure on their own. So there's a difference there around the rural groups who have chosen a product that's hosted, generally they haven't got to worry about a lot of the technical stuff because their hosting organization is taking care of that because they have to to stay in business, so that's a great thing. Whereas the guy in his solo office on the beach in Oregon may have a more difficult time upgrading all the servers and keeping current and those kinds of things. So that's what we're seeing; we're seeing a real haves and have nots, like we talked a little bit before.

Judy Murphy – Aurora Healthcare – Vice President of Applications
Thank you. I didn't realize there was a beach in Oregon, thanks. I'm just teasing you. Liz.

Lisa Levine – Family Health Center of Worcester Massachusetts – Vice President, Operations
This is the last one and this is probably not going to be answered today and I'm going to leave this to you for your stage two for the RECs. You've talked about sort of your evolution process, how you've been developing, yet when I read the testimony, both from today and tomorrow, and all of us have, I see that there's a real concern being expressed by our practitioners and our hospitals about efficiency and about the ability to put in the EHR and not destroy your practice.

Lisa articulated it; it's in almost every testimony. So, what are the RECs doing to help our users, the use of your services for getting the EHR without destroying? I read over and over that people were having to go to a 50% workload. Well, obviously, you said that you only get $2,000. If you gave up half of your patients for a day or two or six, your $2,000 is gone. So, I'm challenging you, Mat and Paul and Clayton, as users of your services, what are you going to do to help us be more efficient?

Paul Kleeberg – Minnesota/North Dakota REACH – Clinical Director
Having been a doctor that's gone through this process and felt the pain, the idea is you don't just do workflow redesign once. You keep doing it and doing it and doing it. I mean, to become an effective user of an electronic health record you constantly have to look at what you're doing and re-evaluating it.

Now, there's good news. MGMA came out with a study not too long ago, some people will argue whether or not the value of that was true, but people have used electronic health records for five years in small practices, earned almost $50,000 net a piece per provider after they've had an electronic health record in place.

Now, when you first implement you go down, and after two or three, it gradually comes up, but by five years, there was that much of a difference. That's just the dollars. That's not the quality that you can get out of an electronic health record. I've seen—I'm sure we all have, but—I've seen small clinics in the Iron Range of Minnesota who aren't doing all the meaningful use stuff, but they're printing out quality metrics. They're improving care and they're improving their documentation and they're doing stuff which provides better care and better efficiency and that's because they do that constant workflow redesign and evaluation. I do think, though, we need to look at our electronic health records and look at usability.

Judy Murphy – Aurora Healthcare – Vice President of Applications
Right.

Paul Kleeberg – Minnesota/North Dakota REACH – Clinical Director
That is one of the challenges. I mean just because an EHR right now can allow you to collect data elements, you don't know if it's one click that's right in your workflow or 17 clicks that's down there. So I'll shut up.

Judy Murphy – Aurora Healthcare – Vice President of Applications
No, I appreciate that, Paul, and I think all of us though are saying to you, as our customers of your services, that we need that to happen. We need you to be able to provide best practices. We've talked about it, but people that are sort of coming out of the selection process and are now in implementation, they're now faced with this and we need templates. The bottom-line is they should lead to quality. There is no question.

Mat Kendall – ONC – Director, OPAS
If I may, I would just say one of the best practices is, in fact, reducing your workload to get this implemented. It's painful and it's expensive.

Judy Murphy – Aurora Healthcare – Vice President of Applications
When you talk about that though, Mat, when we go back to you, we want to see the results of that on a Website, because again, we want to see did it do the workflows that you provided, actually do that. Because what we're seeing in testimony is 50% reduction in our productivity, not where we want to go. We want to get the quality and keep our workflows intact. Everybody is nodding yes. We've just got to do it, right?

Paul Kleeberg – Minnesota/North Dakota REACH – Clinical Director
It's a temporary reduction.

M

I think it's absolutely best practices, different systems. I think there are a lot of ways we're going to have to document it, because I don't think there is a way. I wish there was a silver bullet on this. I think it's just going to take a lot of different approaches cobbled together to be successful and we certainly have a long ways to go, but that's part of our challenge. I like it.

Anne Castro – BlueCross BlueShield South Carolina – Chief Design Architect
Okay. I deem this panel closed on schedule.

M
Thank you very much.

(Break)

Judy Sparrow – Office of the National Coordinator – Executive Director
We're ready to begin, if you'd like to take your seats, please.

Marc Probst – Intermountain Healthcare – CIO
We may not have a full quorum here, but we have a full panel and I think that's probably good enough to get started with. Paul Egerman and I had the opportunity to chair the Certification and Adoption Workgroup, which, at the time it was called the Certification and Adoption Workgroup because all we spent our time on was certification. That was quite the activity a year and a half ago. We're now the Adoption and Certification Workgroup, with our emphasis now on adoption. But we really appreciate, one, the work you put into getting prepared for today; and secondly, being here to discuss with this workgroup relative to what's going on around certification.

The questions that were posed to you are eerily similar to the ones in the last panel. In fact, I think they're identical except replace the word certification with Regional Extension Center or vice-versa, put certification into it. But really, we want to talk about some of the challenges and the opportunities that have been associated with certification. We now have a little bit of experience with it. Some of you on the certifying side, some of you on the being certified side. I guess I get to fit more in that being certified side, so thank you so much for that. We have a great panel and really, again, appreciate it. I know this came together quite quickly and we're just honored that you would spend the time to do this and spend some time with us.

Let me just quickly introduce the panel and then let's get right into it. You're in the same time limitations of five minutes each, although some of you might like to be on the no-fly list. It might save you a little bit of energy. Carol Bean, from ONC, thank you for being here. Alisa Ray, she is with CCHIT. Patricia Daiker, which I had to ask how to pronounce her name and I think I did it right, with MEDHOST. John Travis from Cerner, thank you. And Brad Melis, who is a local guy for at least me, from Salt Lake City and he's with ChartLogic.

Carol, if we can begin with you and we'll go. Each of you have five minutes.

Carol Bean – ONC – Director, Certification and Testing
Okay. Am I starting the …?

Marc Probst – Intermountain Healthcare – CIO
I would just start and when it goes to five minutes— Where is the …?

Carol Bean – ONC – Director, Certification and Testing
Essentially, this is all the metadata for me in this particular situation that we have been privileged to come here today. I thank you for inviting us, even though it was at a very short time frame. This is really and truly an excellent time to pause and reflect on what we've done over the past few months. I'm going to just jump straight into some of the highlights. I would like to just, for example, say that we received over

100 applications for authorized testing and certification body. We didn't receive 100 applications; we received over 100 requests for applications and distributed it. At this point, we currently have six authorized bodies—they're listed there—and we are still continuing to review and evaluate the applications.

Based on the questions that were distributed, I thought it would be worth hearing some of the observations—to summarize some of the observations from the ONC perspective reflecting the implementation process. This is just the way that I've classified them. I hope I've been fairly self-reflective of this. I would be surprised if you wouldn't see some of these in some of my colleagues' presentations as well.

We, early on and throughout, have had a lot of concern expressed by various industry representatives and by industry, this is a large, all-consuming category. Two types of doubts were would this be ready in time, especially given the regulatory constraints that we had and would there be enough qualified and competent ATCBs out there to handle the volume. I think I can speak in more detail if you're interested in that later, but essentially, by the beginning of September we had operational testing and certification bodies. By October, we had certified products and by the end of December, we had version two, which is actually the third version of the certified health IT product list live. This particular thing has a lot of nifty little features, which I'll discuss in a little bit.

The capacity: We expected three to six applications. We actually, at this point, have authorized six, as you saw before, and we continue to receive new applications. We didn't know quite exactly what to expect because this is a very rigorous, new process and in estimating the amount of time that ONC and colleagues have spent on this, the evaluation, the entire process to get an ATCB up and running, processing, reviewing, training has consumed 400 to 500 hours of highly specialized subject matter experts per application. That's something that we're both proud of and a little dismayed at the amount of time that it's taken.

With respect to communication, this has been a major challenge throughout. The regulatory process, the development of regulation, has a certain choreography with both the requirements for communication and restrictions on communication publicly that we've had to deal with. Another aspect of that is that the ATCBs are, on the one hand, collaborators, who work together, with one another and with ONC and program operations, as well as competitors with their own intellectual property, which must be respected. So ensuring consistency among the ATCBs from a programmatic perspective, at the same time providing protection for the confidential nature and proprietary information is a very, very tricky balancing act that we are still working with.

There has been considerable stakeholder confusion and this I could go on for days. I won't. This is among the vendors, the providers, the facilities, the public, just all kinds of stuff. We have done unprecedented outreach and education at many different levels of communication; Webinars, e-mails, interviews, phone calls, FAQs; blogs, etc. We are still challenged.

Another thing is the conditions that have been around the development of the testing procedures for use in the testing and certification. The time frame of this has been a major issue, the regulatory time frame itself, because we are forbidden from getting ahead of the regulatory process and so there are certain things that could not even be begun until after we get to a certain point.

Another thing is the alignment of the meaningful use objectives, the criteria, the certification objectives and standards and the test procedures all having sort of increasingly rigorous constraints on what these things can do. So the target has continued to move— Does this mean I don't get to go forward? Yes, it looks like it.

Marc Probst – Intermountain Healthcare – CIO
It won't let her go forward. It should be working.

W
We cut you off.

Carol Bean – ONC – Director, Certification and Testing
You cut me off. That's—

Marc Probst – Intermountain Healthcare – CIO
No, we did not cut you off. We aren't that technically capable here.

Carol Bean – ONC – Director, Certification and Testing
Oh, well. I can say it. It's too bad. These are nice slides; you should be able to see them.

Marc Probst – Intermountain Healthcare – CIO
Can you help her get that slide?

Carol Bean – ONC – Director, Certification and Testing
Make it work, Alisa. What do you think we need to do? We need to get—

Marc Probst – Intermountain Healthcare – CIO
I think you need to click on the slide. There you go.

Carol Bean – ONC – Director, Certification and Testing
Yes, the one that's a little blue.

Alisa Ray – CCHIT – Executive Director
Right here?

Carol Bean – ONC – Director, Certification and Testing
You're hired. You're authorized.

Marc Probst – Intermountain Healthcare – CIO
In more ways than one, Alisa. Yes.

W
You're certified.

Carol Bean – ONC – Director, Certification and Testing
Okay. I will do this very, very quickly. I just think these are numbers that I thought would be very useful to you. We did a very brief analysis of the CHPL (the certified health IT products list), the number of certified products, how they balance out between complete and modular, ambulatory and inpatient. We have 161 vendors; this was last week; over half of which are small companies and 22% of which are large companies.

Marc Probst – Intermountain Healthcare – CIO
That's amazing.

Carol Bean – ONC – Director, Certification and Testing
I think we have satisfied one of the objectives; it was to broaden the playing field.

This is, I believe, my final slide and I wanted to just basically say CHPL Version 2 went live right before Christmas. Merry Christmas. It has many, many new search, filter, sorting capabilities. It's got automated back-end operational capabilities for loading, uploading for the ATCB's approval process for ONC. Most important, it provides a way for the providers and hospitals to generate that all-important EHR

certification number that gets reported to CMS. In addition, just last week we went live and published the certification program final rule for the permanent certification program.

With respect to the CHPL, having had approximately 2,000 page hits a month since we started this thing in September/October, in the last two weeks we have had over 150,000 page hits on the CHPL. So that's also good news. I apologize for going over, but thank you.

Marc Probst – Intermountain Healthcare – CIO
No. That was important information. Thank you very much, Carol. At $2 a hit, we can pay for this thing. Thank you again. Alisa, now that you know how to use the clicker, please.

Alisa Ray – CCHIT – Executive Director
Madame Co-Chairs, members of the committee, thank you so much for inviting me today. My name is Alisa Ray and I'm here in my capacity as Executive Director of the Certification Commission for Health Information Technology. I'm delighted to have the chance to talk with you about EHR certification. I'll answer the questions you posed to us.

Let me speak first about the commission's ONC-ATCB certification process. We were among the first authorized in early September. We opened our doors and began taking applications on September 20th. My first slide shows the rapid readiness of the EHR companies and strong demand for this new program. As you can see, it's continued all of the way through December.

The basis of our program, the criteria, the standards, publishing the final rule and the NIST test procedures; using these requirements and our experience with certification we built a tool kit for vendors to make it easier for them to prepare for the inspection. This tool kit includes test scripts that flow a little bit more like a typical, clinical scenario. It provides some optional test data and some guidance on how to use the interoperability tools and a few more things. We ramped up our testing capacity. Typically, vendors are able to schedule an inspection with us within two weeks of application if they've prepared and practiced.

The next question you asked is what has been the outcome and the results of the commission's ONC-ATCB program. My next slide shows this. Since we launched we've certified 131 EHR technology products. That was last week's number. There are more. Of these, 92 were tested against the eligible provider criteria. About 80% of those were complete EHRs. Thirty-nine products were tested against the hospital criteria. About 45% of those came through as complete EHRs.

As part of fulfilling our responsibilities as an ATCB we regularly survey vendors on their satisfaction with our services. From a survey in November, we can report a high rate of satisfaction with the process and the ability to schedule. This slide shows about 92% satisfaction with the testing process, certification testing and then another slide shows a 97% satisfaction with the ability to schedule a test date.

The last slide I have, these results indicate the greatest area or opportunity for us all to improve. It lies in the area of satisfaction with the content of the certification materials. I think it's some of the themes that we've talked about today, so despite supplementary guidance, additional education developed by CCHIT, there is still some confusion around the criteria standards and test procedures. There is an opportunity here for us.

What were challenges to certifying vendors you asked me about: We've experienced several. In the early days of the program, a lot of start-up—vendors without experience in certifying their products, they had a lot of trouble getting started. They were unclear how to interpret the criteria, the standards themselves and the test procedures. Their confusion was compounded by some of the early typos or final rule errors around the public health surveillance. We had a lot of questions about that. Of course, that's been resolved with the fix to the final rule. A more difficult problem that Carol alluded to has been the evolving nature of the NIST test procedures and tools. They are frequently updated and that created

concern to the ATCBs just with their program operations, but also vendors, who were in the middle of their certification and testing. I'll talk more about this later.

We've also identified an issue. It's of special importance to hospitals, who've already installed technology. Many have vendor certified EHRs. That's great, but many don't. They built their IT capacity over the years, through multiple commercial products, internal development or a mix of both. Without the ability to certify the self-developed, sort of legacy technology in place, some hospitals could be blocked from the incentives. So to help them, we've developed a special alternative to the commercial EHR certification. Of course, it uses the required standards, criteria and test procedures. We'll launch it next week, but it includes some supplementary, educational and assessment tools to assess gaps, to help them certify their own EHR technology in place if that's necessary.

The last question: You asked me to comment on the commission's experience with ONC and NIST. One challenge is available, a clear and consistent way for all six ATCBs; there are six now; to communicate uniformly and ask questions. We have weekly teleconferences that Carol leads. These are helpful. We always run out of time because these topics are very challenging. We receive direction verbally. Sometimes people interpret things a little bit different, so we recommend that ONC publish the decisions made on these weekly calls so that all of the ATCBs, especially the ones who were authorized later, after the program start, have access to those decisions and can reference them.

Earlier in my testimony, I noted the challenges that arise from an evolving set of NIST test procedures. We recommend that updates to test procedures should be planned with opportunities for comment in addition of a pilot process to improve some more quality assurance with those. Our staff also notes that good implementation of interoperability testing would require some more robust testing tools. Currently few are available. There is a lot of manual, visual review. That can be prone to human error. Guidance documents and training would also improve the consistency of testing decisions across the ATCBs in this area. We hope that's an area that folks will look at.

Just in conclusion, the commission wants to thank you for the opportunity to be here and comment today. It's important that we acknowledge the hard work and dedication of our colleagues at ONC in this. They've been wonderful collaborators, who have been charged with initiating the certification program. Through our own experience with developing certification programs we know how hard this has been and it will continue to be a challenge for us, but I'm confident that as we continue to work together we'll meet those challenges and will facilitate adoption of good health IT. Thank you for the opportunity today.

Marc Probst – Intermountain Healthcare – CIO
Alisa, thank you very much. Appreciate that. Patricia.

Patricia Daiker – MEDHOST – Vice-President, Marketing
Members of the committee, thank you for the opportunity to share our experiences with you on this most important topic. My name is Patricia Daiker and I'm an RN and Vice-President of Marketing at MEDHOST. MEDHOST is a provider of cutting edge, software solutions for emergency departments with over 240 customers across the U.S., Puerto Rico and Bermuda. We strongly believe that usability is the key to clinician adoption and realizing extreme value that healthcare technology can provide.

Our customers range from small critical access facilities to large IDNs. We knew that our prompt certification would be crucial for many of them, who are seeking RF funding, so we were anxious to achieve our certification. We were granted modular certification for 27 of the 35 criteria fewer than two months from the date we applied and I would like to share some of our challenges and achievements with you.

A primary challenge was that the meaningful use objectives for hospitals did not align with all of the NIST certification criteria. For example, the stage one meaningful use objectives for recording smoking status made no mention of the need to have a re-code value, which is then required for certification. There are

six re-code values vendors had to demonstrate, but only three noted in the meaningful use objectives for hospitals. Our software already has a robust documentation of tobacco usage and we were easily able to add the exact verbiage required to demonstrate compliance, but at the cost of the more clinically rich options are customers are used to. Now our users are left with the challenge of how to appropriately document smoking status.

The changes to the meaningful use guidelines and lack of specificity also led to much confusion. As we follow the evolution of the objectives, our development roadmap was altered to ensure we would have the necessary feature set support the meaningful use requirements, but struggled to know what exactly would be required. When NIST criteria were eventually made available we had done significant work based on what we thought the meaningful use objectives entailed and ultimately they ended up not being necessary.

The actual certification process was not overwhelming. We had one individual from the Drummond Group, who led us through the process and was timely in answering our questions. Remote testing was very convenient and having access to the conformance tools so we could validate our features prior to certification was very beneficial. The actual test day was very orderly and smooth, but we had practiced our demonstration thoroughly and were well prepared. I would recommend a more scenario-based demonstration that emulated the natural use of the applications. As the criteria were tested individually there was significant re-work or abnormal use of the system to create a defined result.

In regards to the outcome, I'm pleased to announce that we passed all of the criteria we attempted. Unfortunately, due to the lack of clarity, we misinterpreted one guideline and opted not to test on formulary checking based on the assumption that it was related to payer specific formularies. After our certification, we learned from other vendors that our hospital formulary feature did meet criteria. Additionally, we didn't believe our customers would want to submit surveillance and immunization data departmentally, assuming the hospital would want to undertake that effort. Since our certification, we have been asked by our customers to certify on these additional criteria, as their inpatient systems are not capable. So therefore, we are scheduled for recertification on these three items in February.

Regarding communication with ONC, CMS and NIST, we found it very difficult to get specific answers. I actually submitted a detailed list of questions on August 20th and did not get a response until November 12th. By that time, we were already certified. The response that we received was just a link to their FAQ Website along with some suggestions to e-mail again if we still had questions. I've heard similar stories in the industry from our customers about the inability to get clarity and responses. Since I have been through the certification, I personally have received many questions from our hospitals seeking clarity or more information from me so they can construct their plan to achieve meaningful use. The lack of resources to assist hospitals in understanding how these guidelines apply to their institution seemed to be a universal problem. In the end, much of the education and information about meaningful use was obtained from the Federal Register itself, HIMSS Webinars and from the Drummond Group.

We were very happy that the ED was included in a great number of meaningful use objectives, but found that the NIST procedures were not geared to the unique needs of departmental systems. For example, we were unable to certify on ED quality measures because we could not demonstrate measures for the entire hospital. Our system does generate all of the necessary emergency department information, but obviously, we wouldn't have the inpatient data. This leaves our customers in an awkward position of having to unnecessarily move emergency department data to another reporting mechanism so that they can then submit their quality measures.

In conclusion, we support the HITECH Act and meaningful use initiatives, but believe that they need to be more than feature sets and reporting requirements and more about how clinicians work so the benefits of the software can be fully achieved. Thank you, again, for this opportunity to testify.

Marc Probst – Intermountain Healthcare – CIO

Thank you, Patricia, very much. John.

John Travis – Cerner – Senior Director and Solution Strategist, Regulatory Compliance
I wish to thank the committee for the opportunity to appear before you and reflect on Cerner's experience going through certification. We used CCHIT as our ONC-ATCB and my role in the certification effort was more or less as the football coach and the facilitator, putting our team together and maintaining contact with CCHIT, as well as ONC, CMS and NIST, because really that job calls on you to be dealing with all of those entities. We had been through the experience with CCHIT dating back to 2005 for certification for ambulatory ED and inpatient EHRs and so we felt we knew the process fairly well, so that maybe was a bit to our advantage over somebody who had not been through this process before, but nonetheless, there were challenges.

Certification, I think, for most vendors is a team effort and works as an and because it's few of our day jobs to be dealing with certification. I myself am in product management and have a lot of other things, such as ICD-10 and HIPAA security and privacy to deal with, but we'd emphasize to other vendors you have to prepare early and often and involve key subject matter experts from across the organization. We also found dating back from the original set of recommendations that the HIT Policy Committee developed in June of '09 that every round of objective definition, HHS rule making, NIST test procedure development bore some potential for new development requirement. There wasn't a round that didn't go by that there was not a material change.

We also had issue through our certification process with limited or no notice by NIST of changes to conformance test tools that were contained within the test procedures, so while there was control and advanced notice as to the test procedures themselves, there was no notice within the test procedures as to links conformance tools. In one case, we had an update to a conformance test tool the very day of our inspection that was effective for our inspection, so we obviously had no prior opportunity to test with it. So obviously, a little bit of an impact on vendor dry run efforts when that's what occurs and some question as to the ability of a vendor to prepare when you have that kind of thing happen.

The other thing is the stability of the test procedures and we appreciate that there was rapid change and rapid evolution to them in a short span of time, but we think there is risk for market perception and what a vendor certification means, depending on when the vendor certified. Certainly, as we saw with the change in some of the guidance around the automated, calculated measures, especially for what you might call the ED plain language interpretation versus the FAQ interpretation of unique patient. There are pretty big differences between what vendors who certified prior to that FAQ might be certifying if they were going through that today.

We believe that some important clarification in terms of barriers is needed in the future for the coordination of quality measure specifications as was highlighted earlier in the panel. Between things like the RHQDAPU core measure specifications used by CMS for Medicare Part A in the DRG update and the measure specifications used for meaningful use, particularly what is the version that providers are expected to provide at a station based upon the RHQDAPU specifications updated twice a year, in April and October. We certified using the version that proceeded the 2011 federal fiscal year. Over the course of the next two years, what version is going to prevail for providers to have to attest to? We maintain solutions for both. We're quite confused about what to offer to the market between RHQDAPU and meaningful use as to the content packages that go with those.

We also believe a more explicit statement is needed for specification of the automated, calculated measures than regulatory text. We're beginning to see a little bit of that but, quite honestly, it's inadequate and there's very broad interpretation possible under many of the measures.

We ourselves raised the question on the ED patient when we saw the original FAQ basically saying to ONC, "Did you really mean to say that because the rule says ED patient with no qualification." We were glad to see the clarification came back. But guess what? We're going through a round of update to

enable both of the methods to be possible for our clients. Those are things that can work to be complicating to the efforts of vendors on getting ready and dealing with their client bases.

From a success standpoint though I do have to, despite what may sound like griping, applaud the staff at ONC and CMS and NIST. Carol and I have exchanged e-mails and I feel like at times we wore her staff out, but we did have a lot of questions and I think that I may be a little bit at odds with my colleague on the panel. We actually got, I thought, a fairly good response back, but operating within constraints. You can't contrive regulatory guidance in an FAQ beyond the authority of the regulations.

The other thing I would highlight that really we thought worked very well, the inheritance concept in the certification rule is a wonderful provision that I think most every vendor with production install basis across more than one release are going to want to take advantage of. I know we did and I thought that that was a very good adjustment in the final certification program for the temporary certification program, that final rule.

Some of, just to review very quickly, what did not work so well: I've highlighted most of them; maybe the one thing to add in here is to consider that as you're looking ahead to stage two the pacing of the criteria development, we're already in the same boat we were and I don't see it getting any better. I see it getting worse. We ourselves, we've made development planning for what our development effort is already for the first half of 2011, which would probably be the timeframe we'd like to work on for stage two if we knew what it was we were to work on. We have this little thing called ICD-10 we're working on to enable that we're trying to stay well out in front of and it's a lot in the same span of time.

Then we have operating guidelines out of the Affordable Care Act right on the heels of that. So I understand what the PCAST Report is trying to get at, but stand back. Take a look at what you're asking the vendors to do, much less their clients. Realize that collectively we have in an 18-month to 24-month cycle introduced some new major release from start of prioritization and funding in what will develop to the time that many of our clients are able to even begin working significantly with that.

With that I think I'll wrap up. I have one very last observation about the CHPL, just to introduce a question and that is in its publication. If we understand it right, each vendor not only may have all of their listings reflected, but also if they had done name changes on their certification label those get listed on a par level with what their current listing is. For us, we had some name changes that we clarified on some product names included in our label; both are listed out there in an equal basis.

We also tested over multiple days. We had a certification announced of a modular result on the way to being a complete EHR and I think both are listed. We don't think that helps with clarity and we think it might work better that if for a vendor listing you had a footnote or a reference on the detail page that would show the change history for the vendor's listing. But right now our clients go and open it up and we get questions of what do I pick when they all are more or less the same thing, just differentiated by version.

Thank you very much for the time and for the opportunity to make comments.

Marc Probst – Intermountain Healthcare – CIO
Thank you very much. Brad.

Brad Melis – ChartLogic – Founder and Executive Vice-President
Thank you for the opportunity to be here and for this committee. I'm Brad Melis, the Founder of ChartLogic. ChartLogic EMR was developed in 1996 by my company and a physician, Bruce Jorgensen, in Utah, who had a very unique vision about how technology could bring cost savings and improve patient care. Today ChartLogic has users in more than 40 medical specialties. In recent years we've focused our energies and resources into serving surgical subspecialists. This largely has to do with our ability to meet the needs of high patient volume physicians, who are used to dictation to keep up with patient

volumes. Many of our physicians see as many as 60 or more patients a day and need a technology solution that does not slow down their process.

We carefully followed the CCHIT requirements over time and determined for us that they were too restrictive to allow us to continue offering our users the data entry methods that they had learned to appreciate. As a company, we concluded that until Health and Human Services took its unique leadership role in defining appropriate standards widespread EMR adoption would likely not happen. We were very pleased when this finally occurred. We carefully followed the discussion and reviewed the details of the interim final rule and concluded that the ARRA certification requirements were more flexible and would not make it to fully impact the key features of our product or our clients' workflow. Fortunately, the final rule did not come as a surprise because we had been following and building towards certification. It was with relief that we read the final rule and set out to achieve the earliest possible certification day.

What did we face as a participant? We chose Drummond Group because they had the earliest certification dates. We found them responsive, cooperative, yet firm in their adherence to what the requirements were. We ended up being the first ambulatory EHR to receive full certification. Generally, the test scripts provided by ONC and the test proctoring sheets provided by Drummond Group were excellent. It appeared to us that Drummond's sheets were practical and contained enough detail so that our questions were few and were rapidly answered by the Drummond Group; however, there were some difficulties with the test scripts.

There were other difficulties for us as well. The range of reporting requirements that were set forth seemed onerous and, in fact, proved to be a very difficult development challenge for us. Fortunately, we were able to work through those things. One challenge we faced was in finding definitive specifications for some of the objectives. We also encountered some minor problems with the CCR validation tool. It would be very helpful in the future to have specs and fully tested validation tools for all outgoing and incoming messages. With stage two, this is likely to be even more important. We know that this is being worked on and as early participants, such issues were to be expected.

We also had some difficulty with the certification of our electronic claims messages as required by the exchange prescription information. The NCPDP standard used by Surescripts for live data transmission did not match the standard required by the NIST test scripts. This meant that we had to develop a version for certification that is not presently used by any physician practice.

What might we suggest for stage one and future stage two certification? Somewhat more completed detailed NIST test scripts, which would have been through a review and input from participants ahead of time. We found that the Drummond proctoring sheets were more complete and easier to follow during this process in our internal dry runs. Full specifications and tested validation tools for all messages; related to the above, a rapid response form or blog to notify vendors of official clarifications to testing specifications, etc. Caution on using clinical quality reporting measures, which rely on SNOMED until the standard is widely used throughout the industry.

In closing, I'd like to thank all involved in the Standards and Policy Committee to the submitters of public comments, to the people at ONC. They put together a set of standards and criteria for both certification and meaningful use that is generally reasonable and rational. This criteria both pushed the envelope of present health IT product standards and yet still maintained flexibility for product uniqueness and custom physician workflow. While we fully support the certification standards, we strongly urge this committee, strongly urge, to consider usability of EMR, which I found interesting only occurred at the very end of the last panel's discussion. Ultimately, "meaningful use" relies upon the physician. Thank you.

Marc Probst – Intermountain Healthcare – CIO

Brad, thank you very much. To the whole panel, thank you. There's obviously been a lot of advancement around certification and it's interesting to see some of the things we've worked on actually coming to

fruition. There's also been challenges, obviously, with the opportunities that are out there. Thank you for taking your time and thank you for putting that information together.

I guess I'm looking for name cards to go up to get some questions going. My guess is there will be a few. Lisa, it looks like down there in the corner you're all set.

Lisa McDermott – Cerner Corp. – Sr. Architect
I'll go ahead and get started. This question is to Alisa Ray. You mentioned that your CCHIT is going to provide some self-help tools for providers that may have homegrown solutions or solutions that they may need to get certified. Is that correct? Am I understanding that from your reference?

Alisa Ray – CCHIT – Executive Director
Yes, that's true, Lisa.

Lisa McDermott – Cerner Corp. – Sr. Architect
So as a part of that, is there going to be a decision tree to help them understand if they do, in fact, need to be able to go and do a self-certification and then, as it relates to kind of guidance on how to organize themselves if, in fact, they do have to proceed with the certification? Because I think that's a common thing we get and we've been through the certification. Some of these organizations have, but is there going to be tools and techniques to help them get themselves organized if they do?

Alisa Ray – CCHIT – Executive Director
So, sure; we're actually launching this program next week. We've pilot tested it and we've communicated a little bit about that, but the important thing is that it follows the required testing, right? The criteria and everything, but you may need some extra education. So we've developed some on-line tools that will allow a hospital to do a self-assessment against the criteria, matching the different systems that they have in place. They can see well in Portal List has it been certified already. Is there a gap? Is it an older version that hasn't been certified? You would make some notes if it was self-developed.

We'll have an on-line community of practice because provider's hospitals are often collaborative and want to share solutions or ideas. We'll moderate that, of course. Then there are some other on-demand, educational resources that we're building too. Again, the theme here is that we need a lot more information and if you do need to do that you'll need some help.

Marc Probst – Intermountain Healthcare – CIO
Okay. Liz?

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
Great testimony and written testimony as well. Very helpful. One of the things that several of you talked about in the process from vendors that were getting certification, as well as in your testimony, is the following statement: Vendors are required to create functionality, to obtain certification, but will not be used by the customer. So it creates a quandary for us as customers and as vendors and as certification bodies because I know for a fact using two of the vendors at the table, that you have functionality out there that you specifically told us not to use. So can we talk about that kind of ... that we've created and what we're going to do about it because they're supposed to be using a certified product.

Marc Probst – Intermountain Healthcare – CIO
John?

John Travis – Cerner – Senior Director and Solution Strategist, Regulatory Compliance
I think Brad highlighted one of it and I was smiling when he was talking about the NCPDP test, because we ran into the very same issue. That was actually one of them, the implementation specification this used was not the Surescripts implementation specification, so what we certified is not what – and

interesting enough, I saw Surescripts listed as an ONC-ATCB. I wonder what they use. So here you have a standard in use in the market and the different requirements for certification.

Another thing that we ran into was with the CCD standard and honestly, since changed, testing around what it meant for describing attributes of a procedure in conjunction with a diagnostic test result. It was not very well designed for diagnostic lab results. I don't know the particulars. We can probably provide them to you, but we actually, during late stage dry run, working with CCHIT, we went and took the issue and were talking quite at length with the NIST staff about what to do and that let to, if you look now, there is some very detailed guidance about the procedure section of the CCD.

I think that early on around the time frame we went there seemed to be almost some pointing to the blogosphere for resolution to things that were interpreted issues of the test specifications, which we found rather bizarre. So I think that a lot of the test based code changes we had to make were for the sake of the stage in time, the conformance test tools were at. There were either some errors or incompleteness or literal minded application of them in some ways by the test procedures if we have to pass the test. I mean at the end of the day in some respects, given what we're given to do, we do what we have to do to pass the test. So those are some of the experiences we had at least.

Patricia Daiker – MEDHOST – Vice-President, Marketing
I can address ours as well. Basically, it was a difference in how our software works and what the criteria specifically asked us to demonstrate. One of the ones that come to mind was drug-drug interactions and allergy alerts. So in our software we have different levels of drug-drug interactions as provided by First Databank, which is our vendor, so some drug interactions are desired and others are contraindicated, so you need to be able to display those meaningfully and ratchet up or ratchet down as perhaps the providers need those different levels of alert.

They also had us apply that same logic to allergies. When you're talking about allergies it's hard to decide which ones to turn off or which ones to not display. There is no clinical standard that patients are educated on to what their allergies are and so again, we're an emergency room system and I'm an ER nurse at heart, so if a patient tells me at triage they're allergic to something, until I know better I'm going to believe it. To conditionally suppress some of those things, which is what we're required to do for certification, we had to check the box.

At that point, to be certified is a business driver. We would not be in business if we weren't certified. So we were able to suppress part of the allergy alert that we show. I wouldn't recommend it, because it's now opening up a patient safety issue, but it did satisfy the criteria. I think the intent was more about an allergy versus a side effect of medication. There needs to be a differentiation there, because if you're allergic you're allergic and to say you had maybe a rash one time, the next time you might have anaphylaxis. So it's a slippery slope along that route, but again, I wouldn't recommend you turn that on because we're not sure which one you should turn off.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
Brad, did you want to add something?

Brad Melis – ChartLogic – Founder and Executive Vice-President
I mentioned in my testimony the reporting requirements placed on vendors. Our staff is still wondering where some of this information is going to be going. While we obviously felt the need to be in conformity for capturing the data, the clinical quality measures that are being requested still raise a sort of sense of what did we do this for. Not all, but some of the reports just left us with that impression.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
We'll go back to the other gentleman.

John Travis – Cerner – Senior Director and Solution Strategist, Regulatory Compliance

I did want to say one more thing. Brad brought this to mind and it was mentioned earlier, the smoking status. The responses are actually different between the quality measures where smoking education counseling is part of the RHQDAPU quality measure program for heart failure and AMI from what meaningful use calls for. So there is a contrivance, but I know you'll hear about this tomorrow; I read some of the testimony of the providers you have in panel tomorrow. But we get a lot of questions about do I have to use the system the way it was certified as to functional workflow.

We've tried to tell our clients I don't think that certification criteria prescribes how you use it. For example, we certified one particular way; in CPOE, we certified a physician placing the orders. Does that mean that a PA or advanced practice nurse can't place orders using the CPOE and have it count? Of course not, but there are dozens of repetitions of that where we get questioned about how did you certify. I think that this is an area that clarity could really, really help.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
Carol?

Carol Bean – ONC – Director, Certification and Testing
... to second that. I think that there is no argument here, both beneath the clarity, but also, I think that there are two things that I would like to highlight here. One is that the test procedures cannot introduce requirements that are not in the criteria and so the test procedures themselves are very, very literal. If it's not in the criteria or it's not in the standards, which derive from the meaningful use criteria and objectives, we can't test to it. So there's this sort of waterfall thing that we're all operating under, sort of struggling with and it's, believe me, just as painful for me to have to say, "Yes, that's what the test procedure is. That's what the certification criterion is." So I think that one of the answers is better, earlier, much more detailed communication among those various aspects.

That leads to the second point, which is there is a difference between meaningful use, the way that something is used, the way that somebody attests, etc. and what the system does and is capable of doing. That, I think, we need to take responsibility for much of the confusion that exists around that to be able to clarify what's a behavior, what is optional in terms of what you do in your practice to take care of your patients, etc., whatever those are. Versus what does the system or the product or whatever have to do to check the box, which relies on the others, so there's absolutely no argument from us. I think that the more conversations we have, the more input we have from all of our stakeholders the better we can do at aligning these things that right now are not aligned as well as they really do need to be.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
That's extraordinarily helpful. I think what we're looking for, both for the Policy Committee and for the Standards Committee, is also what's missing. So at some point we want to hear from you what standards are not there. In your testimony, there is allusion to RxNorm. There is allusion to LOINC, I mean both today and tomorrow, so the other thing we need to know is what have we not given you, from both a policy and a standards perspective. So we'll get back to that. I'll defer to Paul and let him ask his question.

Paul Egerman – Software Entrepreneur
First of all, I just want to compliment and commend ONC, Carol, for the work that you've done, 400 or 500 hours.

Carol Bean – ONC – Director, Certification and Testing
Per ….

Paul Egerman – Software Entrepreneur
Per. Okay. Times six. It's very impressive though. I mean this is a very complicated thing to put into place and it's just an observation that I have about the tone of this discussion. We've had hearings about 18 months ago and Cerner and you, John, participated in that. The tone of this discussion is totally

different than what we had 18 months ago where certification was sort of like a lot of suspicion about it. There were people saying maybe certain vendors were manipulating it and people were writing about it all over the Internet. This is all very, very different and so the work that you've done is great progress and also, at least at CCHIT, which I think resisted some of the original suggestions ultimately appears to be very helpful in implementing all of these programs. I really appreciate that.

The comments that a number of you have made about the sort of, call it, stability of the task process, which I call they're like the moving target, is very interesting. I mean you, John, talked about the day of actual testing having a change come through, which I don't even know what to say about that, but I can imagine at best it's annoying when that occurs. I heard a similar comment from somebody I know at Metatech, who told me exactly the same thing. I guess this is a serious issue.

What I'd like to try to understand is the source of that. I mean if I understood your testimony right you got a sense it was probably just the timing and you have a great deal of fear if that will occur. Is that right? Is it just that NIST is new to this? What's causing that problem?

John Travis – Cerner – Senior Director and Solution Strategist, Regulatory Compliance
Yes. How this exactly surfaced, in the particular place that our ... from CCHIT went and where we also went the day of the testing there is an on-line; there are two modes that vendors could do their dry runs and that the conformance test tools can be used. One is to download the tool, go off in your development boil room and go work with it. Do conformance testing that way or you can run it on-line. Well, going through the inspection it was run on-line and so the very day that an update to the CCD conformance test tool was published it was instantly effective, because that's what was linked to out of the test procedure as we went through the live inspection. So lo and behold, here we are going through testing and both we and the ... observed that new version of CCD conformance test tool is in use this morning. Literally, there was no prior notice, so we had no opportunity to work with that and the change did happen to be material to an aspect of something that we were testing later in the day and honestly, it led us to defer that to a second day of testing. So that was very concerning because sight unseen we didn't know if that was going to cause us issue or not, but that just cannot be.

Paul Egerman – Software Entrepreneur
So what's the solution? Is the solution to say if there's a change you get 30-day's notice or something—?

John Travis – Cerner – Senior Director and Solution Strategist, Regulatory Compliance
To me a change in a conformance test tool is a change in method. I'm an old CPA and you're doing a change in method on me, you need to allow— If they did a change in a narrative test procedure, they added a new test step or they added a new data set, that would go through the control process and this does have that process. They update about every 30 days. If you look back on the fall there was an iteration that occurred, I think in the late part of September that went into effect on October 24th. That was to reflect some of the changes in the actual test procedures, the scripts, the steps, the evaluation results. But the underlying conformance test tools that are linked to out of them, they didn't account for that in their change control procedure. It needs to be accounted for that way. We didn't need months. We needed days or weeks, at least an opportunity to go through a dry run with the change to the conformance tool.

Paul Egerman – Software Entrepreneur
So is that something that we should be amending—?

John Travis – Cerner – Senior Director and Solution Strategist, Regulatory Compliance
I think there should be a recommendation if you change the conformance test tool the test procedure that refers to it has been changed. All of those things need to be held to a par level of change control with a public notice face-up in the change control block of the test procedure that the underlying conformance test tool version used by this procedure has changed. Because otherwise you're leaving it to the vendor to go out and maintain quite seriously constant due diligence of the conformance test tool page in addition

to the test procedure. Test procedures have their own change control block. We looked at those religiously. We missed on that one, because it was not—we would not have known it if we hadn't gone in the morning of, literally, and noticed that the version of the CCD test tool had changed that day.

Paul Egerman – Software Entrepreneur
So does that fix it then?

John Travis – Cerner – Senior Director and Solution Strategist, Regulatory Compliance
I think with a 30-day notice of update that would easily fix it.

Paul Egerman – Software Entrepreneur
I guess this is the number-one problem people have right now, the vendors at least have with certification.

John Travis – Cerner – Senior Director and Solution Strategist, Regulatory Compliance
I think vendors need stability in the test procedures, because all of us will try to do a final dry run. Some of us may apply and then set a date for in the future. Others of us may apply only when we think we're confident we'll pass, which has been our practice historically, but we need stability to have that lock-down point where we say we're ready to go. Because when we go to say to CCHIT we're ready to go they're going to throw us to the next available slot with some latitude, but the expectation is you're going to test within a week or two of your notifying CCHIT you're ready.

Carol Bean – ONC – Director, Certification and Testing
I don't want to sound defensive. That is our policy and we obviously missed that one. So that is the policy that is in place and that applies to both, the procedures and the tools and we need to fix that. We need to implement the policies that we have in place a little bit better.

Paul Egerman – Software Entrepreneur
Well, the sense I have is if we can implement that this process would be pretty much perfect, so I think we're all set.

Carol Bean – ONC – Director, Certification and Testing
That's right.

M
Perfect is good

Marc Probst – Intermountain Healthcare – CIO
Walter?

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
My question relates to how this certification is working with respect to security standards and both from the certification side, as well as from the vendor's side. I know this general criteria is very broad in terms of being able to support the HIPAA security and conduct risk assessment and those kinds of things, but in practicality how is that being done, both from the perspective of the certifier, as well as from the perspective of the vendor?

W
I think from our perspective our software already had all of the necessary features, so we didn't have a lot of gaps to fill. The one thing that was a little bit unique to us is doing some of the decryption, because most of our software is done in a fixed client environment, so there's not a lot of external transport of data. Everything we do is HL-7 transport, but other than that all of the security, all of the privacy measures, we have all of those already built into the software and we're good to go.

John Travis – Cerner – Senior Director and Solution Strategist, Regulatory Compliance

I'd echo that. I think very much that most of the requirements were foundational, doing hashing and encryption was a bit of an interesting experience to show it live. We used a secure channel to show that that we use for all of our clinical information exchange, e-prescribing, lab results, so that took a little bit of challenge to figure out just how you trap that and show a hashing routine that's usually within a TLS connection and kind of fire and forget.

I think one thing that I'll commend ONC for writing into the certification rule that gives great flexibility, we haven't used it yet, but we may in the future for modular certification, is being able to determine what's inapplicable or just not feasible for a particular aspect or technology. The example I'll give you is for public health reporting. Emergency mode of access makes no sense for public health reporting. It just doesn't compute. Pardon the pun, but having that flexibility is very, very good regulatory development, I thought, in the final rule and so that I think will help vendors pursuing modular certification particularly if clinical quality measure reporting and public health reporting have the flexibility they need to find themselves in the security requirements.

W
Walter ... a certifying body. Most of the vendors have been able to achieve the criteria. There have been some that have stumbled around the hashing and encryption and had to retest, but as a body, we operationalize it by some documentation review to assess the applicability that John was referring to. That's part of our operational process. I think we've also had on some of our weekly calls security has been one of the areas that we've had a couple of criteria that we've had to have some discussion or clarification from ONC on. Of course, again, that's one of those areas that has to be communicated out to all of the ATCBs, the wisdom that comes from those calls.

Marc Probst – Intermountain Healthcare – CIO
David.

David Kates – Prematics, Inc. – Vice President Product Management
Thank you and thank you to all of the panelists; a question on the broad topic of modular certification, both to the certifying body, Alisa, and to the vendors, John and Brad. From a certification standpoint, what are some of the unique complexities of the modular certification? From the vendor's perspective, what are your customers doing with the modular certified product in terms of aggregating those into something that they can then demonstrate achieves meaningful use and what are some of the questions, complexities, things that we should be addressing in that regard?

Alisa Ray – CCHIT – Executive Director
Well, we are definitely a modularly certified application and I think some of the biggest questions have been your exact question. How do I get the data together? What do I do? How do I move it from point A to point B? Everybody feels they get a little bit of a path because of the attestation right now and maybe there will be more guidance later. I also think, because a modular system and the criteria doesn't have to talk to other systems, but in reality they do, it's a bit disparity between what the criteria say and what reality demands. So all of the history, the patient information, as a modular system, we have to show it, but in reality you really have to share that back and forth, so it kind of puts a very odd who owns it.

The way it works right now is we own it and the inpatient vendor owns it, so there's like a dual ownership there. But I think as we move forward, as interoperability becomes a bigger player and we're really exchanging data and, Liz, to one of your questions, I think one of the key things that does not exist yet is a good standard for allergies. Everybody talks about it and that's one of the A-number-one things we struggle with is how do I, between various databases and drug databases, say penicillin is penicillin or what is an allergen group. So if you talk about sulfa drugs that can be different between many providers. But I think from the modular standpoint, again, it was how do I do that in a world of an emergency room vendor, where the workflow is not the same and we don't have a longitudinal concept of information. So our patient population is different than the inpatient system and that's where we struggle.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
... talked about that. You may want to talk about First Data. I mean they're a reference database ... First Data to others and they don't match. So when you talk about interoperability and modular certification we can have a certified application in our ED, a certified application in inpatient and a certified application with our EP and all three of them are using three different data reference banks that do not talk to each other. At some point, we have to overcome that. If you talk about the complexities of this that is a huge one for us.

W
I agree.

Carol Bean – ONC – Director, Certification and Testing
As a certifier, I'd just echo that we run the tests. We can test the module. We tell them that they pass, but we have to clarify that we are not, in your words, Liz, testing the integration between the different modules.

M
Yes.

Carol Bean – ONC – Director, Certification and Testing
So it's an important opportunity for EHR developers to test modularly, but from the providers, who might be looking beyond meaningful use, that's something that they need to be aware of and that's an educational opportunity.

Marc Probst – Intermountain Healthcare – CIO
John.

John Travis – Cerner – Senior Director and Solution Strategist, Regulatory Compliance
I'll add kind of a couple of things that very much echo the ED example. We've had clients, who are we're the hospital system. We're not the ED system in that particular case. They're really, really struggling with those measures that are like problem lists or some of the other event, only having to be recorded once in the measurement period and might have happened in the ED system and the awareness of that or it may have happened in duplication across systems. So I think the automated, calculated measure is going to be a real challenge for organizations that implemented different vendor solutions for the different care venues that are part of the unique patient concept for the hospital side.

The other thing, and I may be peeking ahead to steal a little bit of thunder from tomorrow, is that I think the vendor listings, as they're labeled on the CHPL, a lot of people are struggling with; this is a little bit like the meaningful use versus how products are certified. If I'm looking at the CHPL as covering my attestation basis does the listing mean a purchase order. Some vendors have listed very general product names and I see issues with that because then a conversation with a vendor becomes, "Okay. I know you certified this general, overarching reference, but I know you license at a different level than that. What is really that, which I need licensed?"

You have others kind of like us where we have a little more specificity in our label and people are asking us, "Do I have to buy all of that from you to be covered? What if I bought something from somebody else or I'm using 80% of what you certified?" There are all kinds of permutations that operate. We're complete EHR and we're looking at some modular things around public health reporting later, but I think that there is a lot of fear that they'll be left exposed if they say, "Well, 80% of what I use is from that vendor," but it's not everything that might be in their label. Or their label is too general for me to make any sense out of and I'm taking the vendor's word that what they license to me is really what they certified. All I can say is I hope for fraud flexibility and enforcement for the rack auditors when they get a hold of this one.

We are trying to tell our clients honestly, as long as you've covered the basis with what you've certified, that some of the practicalities of the way the shopping cart experience are raising some questions for them. I'm sorry, Judy, I stole a little of your thunder there, but I think that it's a fair question. Vendors are the horns of a dilemma with that one because our duty was to certify and, honestly, certification doesn't suddenly create a purchase order for every one of our clients and they would throw us out the door if that were the case. They're trying to work with what they have in their portfolio, trying to make sense of multiple vendor product sources to inform their basis of claim. I do hope that it's a very flexible enforcement regime around that point.

Brad Melis – ChartLogic – Founder and Executive Vice-President
Our perspective would be slightly different. It overlaps a bit, but we're specifically in the ambulatory world. The physicians or medical groups who adopt our technology typically use all of the products, so with respect to certification of any one module they're reliant upon us to have certified to you that that feature, e-prescribe, for example, is fully integrated into our application. It isn't uncommon for us, when we go into a clinic, to have some level of technology already existing like EMR or like document management. Practically speaking, it seems easier for them just to scrap what they have and rather than picking this module from company A and this one from B and something from us, they tend to look to us for the full suite and expect that it is in conformity with government standards.

Marc Probst – Intermountain Healthcare – CIO
Anne.

Anne Castro – BlueCross BlueShield South Carolina – Chief Design Architect
I'm curious because meaningful use one had a couple of administrative transactions in it to begin with and then they were removed. In the course of certifying and how the world is laid out are providers changing their billing systems and their EMRs collectively in general? Because if that comes back up in meaningful use two and they put in a slice of two of the HIPAA transactions into meaningful use and certification does that really cause a lot of modular requirements or what's your experience on that? That's one of the questions I had early on, unintended consequences of having to replace a billing system and an EMR at the same time.

Brad Melis – ChartLogic – Founder and Executive Vice-President
My experience or our company's experience is this: I think that doctors and clinics would like a single vendor solution. It's complicated enough to try to understand what all of this means, to be certified and to be in conformity. We typically find; I would tell you more than half of the time and it's probably higher than that; it might be 60% or 70% of the time they're willing to disengage from any other technology they have to get into a comfort zone of this is all under one umbrella and certified—

Anne Castro – BlueCross BlueShield South Carolina – Chief Design Architect
But that's such an exponential degree of change in the office to have billing changed, statements changed, appointments—

John Travis – Cerner – Senior Director and Solution Strategist, Regulatory Compliance
But the fact of the matter is they've done this many times. If you talk to most physicians they've changed billing systems two, three, four, five times. It's almost a ritual now that they go through because the vendor goes away. The lady who did billing or the clinical manager left and everybody is disgruntled, so yes, it is frightful, but the fact of the matter is the overriding issue to me is the fact that they want comfort that a vendor can solve all of these problems rather than patch working things.

Anne Castro – BlueCross BlueShield South Carolina – Chief Design Architect
They have one phone number to call.

John Travis – Cerner – Senior Director and Solution Strategist, Regulatory Compliance

Well, yes, and they're trained that way. I think consultants train that. I think they go to their academy meetings and they hear this. You want somebody to be responsible and our experience is that that trend is increasing, certainly not going the other way.

Anne Castro – BlueCross BlueShield South Carolina – Chief Design Architect
How about the rest of you all?

John Travis – Cerner – Senior Director and Solution Strategist, Regulatory Compliance
Speaking from the hospital perspective, I think that it's a very different reality than the physician office. I think Brad's comments were absolutely spot-on on the physician side, but on the hospital side you find no harder buyer than the CFO. They don't like change. It's a large system acquisition. It's a very large and invasive surgery to replace the patient accounting system. Quite honestly, many of them are still shaking their heads over the inclusion of claims and eligibility as EHR functions. They are revenue cycle functions. They are patient accounting.

Anne Castro – BlueCross BlueShield South Carolina – Chief Design Architect
But they were removed from meaningful use one.

John Travis – Cerner – Senior Director and Solution Strategist, Regulatory Compliance
No, they were pleased with that, but they're still puzzling over its presence in meaningful use two and why it's being regarded.

Anne Castro – BlueCross BlueShield South Carolina – Chief Design Architect
Why?

John Travis – Cerner – Senior Director and Solution Strategist, Regulatory Compliance
A reaction we do get is you know vendor certified 4010A with clarity or with ENAC or other bodies years ago when it was originally implemented and won't that happen again. Won't that address the need? Oh, by the way, for claims aren't we already supposed to be using this? Why is this a meaningful use criteria element at all because Medicare doesn't accept a non-standard claim? Why do we need this? So they're very puzzled.

I confess I am as well as to its inclusion, but I don't know that it's enough to induce a new buying behavior out of them. Many of them probably are looking at same vendor for core institutional functions, of which patient accounting would be one. Although, if they buy in a block apart from clinical they'll buy revenue cycle as a block and go single source on that, so you might see a clinical EHR vendor and a revenue cycle vendor living side-by-side. That's not probably the majority, but it's not at all unusual. Many of those older financial systems are very old and have been kept going. Some of them are 15/20 years old and still in use.

Anne Castro – BlueCross BlueShield South Carolina – Chief Design Architect
Well, in 4010 and 5010 and ICD-10 and the billing is all going on at this time—

John Travis – Cerner – Senior Director and Solution Strategist, Regulatory Compliance
It's going to create an opportunity for them, certainly, for mediation.

Anne Castro – BlueCross BlueShield South Carolina – Chief Design Architect
It's a big burden.

John Travis – Cerner – Senior Director and Solution Strategist, Regulatory Compliance
It could coincide to a timing, but they would say there is nothing compelling about meaningful use towards what they would expect for those systems anyway, because they have to deal with them and the 5010 is going to precede stage two by almost a full federal fiscal year.

Marc Probst – Intermountain Healthcare – CIO
We have about four minutes left and a couple of more questions. Judy?

Judy Murphy – Aurora Healthcare – Vice President of Applications
Picking up on the thread that we started a little bit ago, differentiating a certified system for meaningful use or meaningful users, I know that one of the things we've been doing internally. I'm just curious what your opinion would be—Carol, I think this is for you, but the software vendor folks might be interested as well—when we think about the testing one of the things that we've been doing internally to give us guidance in doing that is to look at the NIST test cases that are used for certification. Could you comment on the appropriateness of that and if you are aware that other folks are doing that as well? In other words, as an organization looks to attest for meaningful use they actually use the NIST test cases to understand or add clarity around some of the meaningful use criteria.

Carol Bean – ONC – Director, Certification and Testing
I would be happier if our NIST colleagues were here to respond to that. I feel very confident though in saying that speculating that you wouldn't go wrong looking at the NIST test procedures, I don't think that that would give you the full range of things that might satisfy meaningful use in its entirety, particularly with some of the quality measures and some of the things that have changed, etc. But I think with respect to the things that they address, I don't think that one would go wrong with that.

Judy Murphy – Aurora Healthcare – Vice President of Applications
By the way, just for clarity, you do look at the meaningful use criteria first, but when you're puzzled about what from a compliance standpoint, let's say, you might want to say that you are actually doing it using that to inform you has been helpful, at least for us.

Carol Bean – ONC – Director, Certification and Testing
I think that actually the NIST test procedures in my view are a very useful resource to sort of help translate from the meaningful use criteria through the certification criteria to an actual scenario, test case or something like that. At least that's the way I have found them and I've learned a lot just by mentally following that thread through that.

John Travis – Cerner – Senior Director and Solution Strategist, Regulatory Compliance
I'll offer one that I think has been one of the most challenging ones for our clients looking at trying to use those as guidance. It goes towards the very practical perspective of what do you have to do anyway. To me, no one is more challenging than the electronic copy of the record objective, because there is latitude actually written into how you do it, but you step back and it was a HIPAA privacy right. One would argue without any regulatory change to say you have a right to a copy of your EHR. So if the patient tells you, "I don't want a CCD. I don't have a CCD reader at home. Just give me a rendered PDF. I want to look at this in Adobe and oh, by the way, I want a narrative summary of my diagnostic imaging report," which isn't in the CCD or in the standard, do you get to count it for automated calculated measures? I would argue that you do because in good faith you would have given them what the regs said you should give them, but they didn't ask for it. They didn't want it. What they were asking for wasn't that at all. It was something else entirely, but you gave it to them in electronic form.

So I think that the danger is you can carry that too far as instructive. It's a guidepost. It's a reference, but as a practical matter you might shoot yourself in the foot if you take a narrow interpretation of it and preclude counting things that were good faith efforts, but you still had to give the patient what they asked for anyway.

Marc Probst – Intermountain Healthcare – CIO
Dr. Heyman?

Joe Heyman – Ingenix – Chair, National Physician Advisory Board

A couple of the RECs suggested that one of the barriers for the RECs was the vendors making a guarantee that the person would meet meaningful use. I was just wondering if you guys had any comment on that, the implication being that physicians particularly are missing out on the help that they could be getting from the RECs in even selecting which vendor to use because the vendors themselves are guaranteeing that they use physicians who will meet meaningful use.

Carol Bean – ONC – Director, Certification and Testing
I'll take a stab at that one. I can say with 100% clarity, we're not guaranteeing anything. We see certification as a functional effort, saying that we've passed certain criteria, but meaningful use as behavioral and obviously, we can lead a horse to water, but you can't make them drink. In our world it's all about proper implementation and making sure that the system is designed for their workflow, what they're doing so that as a byproduct they'll hit those guidelines, but there's no way that you can, as a vendor, really guarantee that the people doing the work will do the work.

John Travis – Cerner – Senior Director and Solution Strategist, Regulatory Compliance
We had one prospect that had a very large practice and inpatient setting. Relative to the practice, they were wanting us to warrant exactly that and we wouldn't do it. When we introduced the question of can you assure all 500 of your physicians mean stage one meaningful users as of the same date because that was literally what they wanted in a warranty. We can't warrant your behavior. I think that that's something that if I'm their attorney, if I find a vendor willing to go along with that I've won. But it's very problematic and I think all of us would say we'll work every bit right at your side to make sure you can make the incentive to the degree that we can, but you, at the end of the day, have to be responsible for your own use. None of us are prepared to warrant your degree of use. We'll warrant the software has the capability; that we said it's certified.

Brad Melis – ChartLogic – Founder and Executive Vice-President
I think that as I reflect on the physician population that we typically serve they're still wondering why in the world they're asking a patient about smoking cessation. This is the surgeon, who doesn't even have a stethoscope, let alone typically ask these questions. So I echo the sentiments of the other panelists here and that is no, we will not provide any guarantee because I'm still concerned about their utilization of the tools we provided because they view them to a certain degree as somewhat onerous and some would say extremely onerous. I think that may reflect the type of doctor they are, but many of the specialists we deal with are still scratching their heads going, "How in the world am I going to do this? We don't do this now." So that's my concern is will they do it; not is the feature available. We're certainly not going to hold a gun to their head to say you have to fill in every box or we're going to give you some sort of penalty or something.

Marc Probst – Intermountain Healthcare – CIO
Thank you so much for all of your input. I did have a quick question and I own the microphone at the moment, until I turn it over to the chairs. You mentioned usability. That came up in the prior panel. That came up in your panel. You mentioned PCAST. I think the issue that's coming to my mind is we went through the certification discussion. There was an issue or a concern that this could slow down development; this could slow down new ideas and putting them into the product. Is there any validity of that concern that this process is having an impact or a negative impact?

Carol Bean – ONC – Director, Certification and Testing
It probably depends upon the vendor. I love analogies, so I think what these criteria have done essentially is said you have to have your radio in your car. Well, for some vendors it's easier to throw it in the trunk. Can you change the channel? Yes. You'd have to stop, pull over, go back and change the channel, but you could do it. Well, you could imagine what traffic would look like, or you just choose not to change it all together. I think for vendors that will succeed you have to redesign your whole dashboard to make that radio fit in a place that makes sense for that par and I think there are going to be those, who do and those who don't. That's' where the usability piece comes in. It definitely has to work without

clinicians thinking how they do their work every day or it's the garbage-in-garbage-out syndrome. The vendors have to step up and take that step to do that.

John Travis – Cerner – Senior Director and Solution Strategist, Regulatory Compliance
I love the metaphor, because it's kind of like enabling four-wheel drive while you're driving in the middle of a blizzard and getting out of your car to active it versus being able to turn it on from within the car. For us, I think that on the greater whole we found meaningful use affirming things that we hope were mostly already in our solution. I think the bigger challenges remain in front of us because, honestly, the goals in the PCAST Report it said it very well; they advocate pushing from internal use to seeing the EHR as a public good or to begin to serve public good. I think that's an open question to me right now as we turn to attaching metadata for privacy, quality and information exchange or to implement uniform markup languages that attach metadata to all of the clinical data elements that we'll be exchanging. So if we can beg off the answer, ask us in a year or ask us in 15 months and we probably will or we might feel different.

Brad Melis – ChartLogic – Founder and Executive Vice-President
My sense is what we've seen so far—the requests that have been made, the standards employed—I think are reasonable. The future seems a little ominous and there are many vendors that are probably smaller than we are, who look at this with crossed eyes. It does seem onerous and difficult, but I think it's necessary. This is, in fact, what has to happen. How quickly it happens, the cost of doing that to vendors and doctors to be sure is something that we think a lot about. I mean we look at our budgeting and our resources and things we'd like to do versus what we're going to have to do and they're going to have to make trade-offs. Things that we would love to put in our software may wait, because we have to get what we need to make sure that our clients are in conforming standards to what you folks lay out.

Marc Probst – Intermountain Healthcare – CIO
Very good and very, very helpful. I really appreciate this panel. I have invented a string system that you can put into your trunk around the channel changer, so anyone interested in that in the future, that is innovation, but thank you very much for your time today.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
As we begin to wrap up, I think what we'll do is I'll speak for just a moment and ask my other colleagues to join. We have covered a significant amount of information today. It's been extraordinarily informative. We thank the testifiers. We started with RECs. I think we all discovered there are all varieties sand pricing models offering a variety of services being received at different levels. I think we determined that we need to always focus on usability and get back to are we offering you the right things. Have we discovered the right standards off of those? Are we listening? We've challenged the ONC to get information out there so we can begin to see the results of the programs that are in place. Again, excellent information.

Then it was very fascinating, I thought, to hear from Paul and Marc, as they had started the certification process. They've seen the evolution. We heard from our vendors and from the certifying bodies, as well as the ONC, tremendous progress is being made. We challenged again, do we have the right testing mechanisms in place. Do we have the right criteria? Do we understand it? I think all of us see that we need further clarification. We need better communication. But the honest and sincere work to get that done is happening. We're watching certifying taking place, which gives us the belief that we're going to move forward with certified products and we're going to achieve what's really important to us all, which is better quality of care, so great information, more to come tomorrow.

I'll turn to Judy and Paul and Marc for additional comments before we get to public hearing.

Judy Murphy – Aurora Healthcare – Vice President of Applications
All I have to say is I'm just amazed sitting here that it was just a little over a year ago that the NPRM and the IFR were published. There are not too many places in our lives these days where I think we see the

kind of huge, not just effort, but accomplishments that have been happening in this space and in our life here in this last year. To think that the final regs only came out in July and we're sitting here talking about six certification programs and many, many products being certified. I just get excited about the potential and I think we have to tune things and that's what we're here to talk about. It's the perfect time to step back and to just kind of take a pause and say what have we learned and what things can we tune. That excites me too, putting those final little tweaks on some of the programs.

Paul Egerman – Software Entrepreneur
My observation is similar to what you just said, Judy. It's really amazing to me to see how we've gone in a very short period of time from talking about these things to actually doing it. There has been unbelievably great progress; just look at certification and the RECs. I'm sure in the testimony today there are a number of issues that we still need to work with, but there's really been huge progress. So it's exciting to see and it's hard to imagine that we can make as much progress in the coming year as we made in the last year, but I think we will try to do that also.

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Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
Can we open it up now for public comment, please?

Judy Sparrow – Office of the National Coordinator – Executive Director
This is the public comment portion of the meeting. Please state your name and organization. There is a three-minute time limit.

Harm Scherpbier – Main Line Health – CMIO
My name is Harm Scherpbier from Main Line Health, a multi-hospital system out of Philadelphia. I have a question about EHR certification. I'm wondering if we are implanting a feature and a function that has been certified. It turns out in the live setting, in our environment, not to work or not to work all of the time, not to work 100% of the time. Is there a way or should there be a way that the certifying body could temporarily put that certification on that item on hold until the item has been fixed? I think some things may work in the testing environment while things are being certified, but then in real life you start discovering things. I believe it would be good for the process, although it seems rather complicated, but it would be good to have a way to temporarily put a certification on hold in certain situations. That's my comment.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you very much. We do have one comment on the phone.

Robin Raiford – Allscripts – Executive Director, Federal Affairs
Hello. This is Robin Raiford from Allscripts. I just have a comment, certainly in support of the very robust comments that are being made today about the development cycle and giving vendors enough warning of what they need to do with great respect that the HIT Policy Committee is going to wait for stage one input and what's successful, what isn't successful. When you give a vendor a list of criteria that has to happen and you can't get it in a reasonable amount of time you start pushing stuff in there quickly without maybe shortening some quality testing criteria and then it's in there. It gets certified and just, as the previous comment was made, sometimes it doesn't work or it affects downstream systems, which wasn't obvious because you didn't have enough time to test it.

In stage one, year one, this year we have a little bit of wiggle room because there's a rolling start where people have only 90 days to have to meet this. This is going to be a huge concern when we get to payment year three when everybody has to be, anybody who is qualifying for payment year one in 2011, they all have to be at stage two on October 1, 2013. That's a huge concern or they wouldn't meet their

full year. That means in Medicare they'd miss their payment and that would start craziness if we don't have enough time to get features in a product and get it rolled out.

The other situation that has come up that I didn't hear mentioned today is we have clients that are using an acute care solution in the ambulatory setting, which is meeting their needs for notes, results and orders, but it's not certified in the ambulatory care setting. So they're not being able to get that, realizing that, oh, by the way, they need to be doing all of the criteria set forth by the secretary, so just an issue to be aware of; that people are realizing they have to be on the right product that's certified.

Just a comment to Carol Bean: Thank you for the re-work on the CHPL list. It looks great that you can actually now go in and find things a little bit easier, but a suggestion that you make the field a little bit bigger for the software environment, because it's cutting off the software environment where people actually cannot see that.

My last comment is just in the vendor world we all know we think it's final when the final rule comes out, but we all know it's only final until the next clarification from ONC or CMS comes out about an FAQ. As was pointed out earlier about the changes that had to be made, when the clarification came out about point-of-service 23, that gave flexibility to hospitals; it immediately put vendors back into scrambling to have to fix that report. Because now we have all of those reports that now had to be done both ways, all patients for the ED or patients that were just admitted or are in the observation status for the ED.

Thank you for the opportunity to comment.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you, Robin. Good comments. Just let me remind you, we'll begin at 9:00 tomorrow in this room. I'll turn it back over to Judy.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
She looks surprised. We'd just like to say thank you to the Standards Committee participation and the Policy Committee participation and workgroup, all of our testifiers and audience. Tremendous amount of information today. We're looking forward to the information we'll be getting tomorrow. Thank you.

Judy Murphy – Aurora Healthcare – Vice President of Applications
Thank you.

Public Comment Received During the Meeting

1. The previous panelist was cut off when he was trying to give the website of REC's that are up. May I ask where we can find a list of REC's?